EXPLORING HEALTH BEHAVIOR IN OLDER BLACK WOMEN

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EXPLORING HEALTH BEHAVIOR

IN OLDER BLACK WOMEN

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Older adults, like any other age group, have a diverse set of health beliefs, health seeking patterns, and health practices, all of which have the potential to influence health behavior and ultimately health outcomes. The purpose of this study was to further the understanding of health behavior among elderly African American women, with 'health behavior' encompassing the combination of health related beliefs, patterns of health seeking behavior, and health practices in relation to both acute health problems and acute episodes of chronic conditions. The investigation was intended to answer two questions:

1. What are the health-related behaviors of older African American women?
2. Are age, education, living arrangement, and marital status related to their perceived health status?

This study was both exploratory and descriptive, using content analysis as the method for examining responses related to health behavior among 45 elderly African American women, aged 67 and older living in Allegheny County. The data were originally collected for a supplemental grant to a controlled randomized prospective study entitled Geriatric Health Care and Assessment (RO1 AG08276)**,** funded by the National Institute on Aging in 1992.

Key Concepts of the Noel Chrisman model (1977) for a health seeking process, along with selected questions from the supplemental study's semi-structured questionnaire, provide the organizing framework for this exploration. These concepts include: symptom definition, illness-shifts in role behavior, lay consultation and referral, treatment actions and adherence. Given the importance of perceived health status, this variable was evaluated for relationships with selected demographic characteristics: age, education, income, living arrangement and marital status and other health behavior measures included in the study. In addition, I examined perceptions of care and race and gender preferences since these were themes emerging as a result of the questions asked in the study.

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1.0 INTRODUCTION

Within cultural communities, there are natural helping resources, informal networks, health promotion campaigns, and formal systems of care that older adults use and respond to in their search for help and in decision-making related to their health. Included among these resources are such entities as religious institutions, as well as extended family, friends, and lay and professional "health messengers," all operating on many different levels and often with competing voices. Older adults, like any other age group, have a diverse set of health beliefs, health-seeking patterns, and health practices, and the various entities referred to above have the potential to influence individuals' health behaviors and, ultimately, health outcomes. Additionally, one's perception of their health may play a role in health behavior and outcomes. In fact, an individual's own self-assessment of health is a reliable indicator of his or her health and well-being (Agency for Healthcare Research and Quality [AHRQ], 2002).

The purpose of this study was to further the understanding of health behavior among older African American women. In this study, health behavior was seen as encompassing health-related beliefs, patterns of health-seeking behavior, perceptions of care, and race and gender preferences. The investigation was intended to answer two questions about this group of women:

1. What are the health-related behaviors of older African American women?

2. Are age, education, living arrangement, and marital status related to their perceived health status?

This study was both exploratory and descriptive, using content analysis as the method for examining responses related to health behavior among 45 elderly African American women, aged 67 and older, living in Allegheny County. The data were originally collected for a supplemental grant to a controlled randomized prospective study, the *Geriatric Health Care and Assessment* (RO1 AG08276), funded by the National Institute on Aging (NIA) in 1992. The Principal Investigator was Dr. Myrna Silverman, Professor at the University of Pittsburgh, Graduate School of Public Health.

Key concepts of Noel Chrisman's (1977) model of the health-seeking process provided the framework for this exploration's data analysis. The key concepts outlined in the Chrisman model, which are discussed in more detail in Chapter 2, include: symptom definition, illness-related shifts in role behavior, lay consultation and referral, treatment action(s), and adherence.

In 1977, Noel Chrisman introduced a concept he referred to as the health-seeking process, a model to conceptualize behavior or "steps taken by an individual who perceives a need for help as he/she attempts to solve a health problem" (Chrisman, 1977, p.353). The concepts from the Chrisman model were selected for this analysis because they provided a concise framework to understand how individuals might respond to a health issue and they were compatible with the health behavior questions used in the original study's interview. Chrisman (1977) originally developed the model to understand behavior during an acute illness, but

subsequently also used it for chronic illness. In this analysis, I used the Chrisman concepts to understand the experience of older African American women in response to acute and chronic illnesses as well as acute episodes of chronic illnesses.

It is important to understand the context of the women studied. Therefore, the remainder of this chapter includes a brief description of the older African American population and of the general issues faced by women as they age. It then, discusses, the impact of individual-level factors, including age, education, income, living arrangement and marital status, and systemic factors, such as bias and inequality in health care, Chapter one provides the context in which older African American women perceive their health, health care, and health-seeking options.

As is common use among many African Americans, in this dissertation the terms Black and African American are used interchangeably and refer to persons having origins in any of the Black racial groups of Africa. This includes individuals who indicate their race as "Black, African American or Negro" or who provide written entries such as African American, Afro-American, Kenyan, Nigerian, or Haitian (U.S. Bureau of Census, 2000).

1.1 OLDER ADULTS

The demographics of aging continue to change dramatically, with the aging population growing rapidly (Federal Interagency Forum on Aging Related Statistics, 2000, p. xii). According to the 2000 U.S. Census, there were 281,421,906 people in the U.S.; 12.4% or 34,991,753 of the population were age 65 and older. Nationally, 10.4% of males were 65 and older while 14% of females were 65 and older. Of the elderly population, there were 2,822,950 (8.1%) Blacks 65 and older; Black males comprised 6.5% of the older population and Black females comprised

9.6% (Race and Hispanic or Latino Origin by Age and Sex for the United States: 2000, Internet Release date: February 25, 2002).

During the period when the original study was conducted, more than 17% of the population in Pittsburgh and Allegheny County were 65 or over (Schulz & Kerchis, 1996). Eight percent (8%) of older adults 65 and over residing in Allegheny County were Black as were 18% of those 65 and over residing in Pittsburgh.

1.2 WOMEN AND AGING

Much of the literature on older women identifies them as a population at risk (Williams, Neighbors, & Jackson, 2003). Because women are living longer than men, the health, economic and social challenges of old age are often the challenges of women. The female proportion of the population increases with age. In 2001, women accounted for approximately 58% of the national population age 60 and older and 70% of the population age 85 and older. One in every ten persons is a woman who is at least 60 years old and one of every six older women is a member of a minority group (Administration on Aging [AOA], 2003). Since women have a longer average life expectancy than men and also tend to marry men older than themselves, 7 out of 10 'baby boom' women will outlive their husbands. Many women can expect to be widows for 15 to 20 years (AOA, 2003).

Although women live longer than men, they do not necessarily live better. Compared with men, older women are: three times more likely to be living alone; nearly twice as likely to reside in a nursing home; and more than twice as likely to live in poverty (AOA, 2003). The AOA reported that poverty increases with age and is especially prevalent among older women of

color and older women who live alone. Of the 9 million older persons currently living alone, 80% are women. Three out of five older Black women living alone live in poverty. Almost three-quarters of all older persons with income below the poverty level are women. Over half of the elderly widows now living in poverty were not poor before the death of their husbands. Three out of four persons over age 65 living on Supplemental Security Income (SSI) are women (AOA, 2003).

According to the Office of Research on Womens' Health (Leigh & Linquist, 1996-1997) elderly women of color share several characteristic with all elderly women. First, they outnumber elderly men of color; second, they are more likely to be widowed than elderly men of color; and third, the longer they live, the more likely they are to be affected by chronic illness, dependency and disability. Elderly women of color, bring the accumulative influences of their lifetime experiences as women of color to their health in later life. The health of these women of color is to a great extent a product of who they are in the political context of the larger society and their historical experience. Elderly Black women have experienced oppression for much of their lives; they are part of a cohort who came into adulthood when racial discrimination against Blacks was open and legitimate (Hunter, 1997).

Racial and ethnic disparities in health are critically important; however, serious attention also must be given to gender disparities. Addressing gender issues without consideration of race can create divisive challenges for Black women, who have a unique perspective that combines both race and gender. As Berry (1995) suggested, older Black women experience a 'triple jeopardy' of age, gender, and race, which are evaluated negatively by the larger society.

1.3 AGE, INCOME, EDUCATION, MARITAL STATUS, AND LIVING ARRANGEMENTS

1.3.1 Age

Age appears to have some association with health behavior and practice. For example, in a recent study, data were collected at senior citizen facilities from 214 black women aged 65 and older. Differences in knowledge, beliefs, and screening practices across three age groups were assessed by chi-square tests. Logistic regression modeling was used to determine the effect of these factors on compliance with American Cancer Society (ACS) screening guidelines. Age was inversely associated with knowledge and screening practices. The youngest group (65-74) was about twice as likely as the oldest group (85 and over) to correctly recognize breast cancer risk factors. About 50% of the oldest women compared to about 20% of the youngest women believed their risk for breast cancer was nil. The oldest group was also least likely to have had a mammogram or clinical breast examination within the past year, as recommended by the ACS. Results suggest that educating elderly women, especially those 85 and over, about breast cancer and screening may lead to higher compliance with ACS recommendations (Jones et al., 2003).

Winkleby and Cubbin (2004) conducted an analysis of the Behavioral Risk Factor Surveillance System to assess changes in chronic disease-related health behaviors and risk factors from 1990 to 2000, by race/ethnicity, age, and gender. They examined the results of 16,948 black, 11,956 Hispanic, and 158,707 white women and men, ages 18 to 74 on such measures as: cigarette smoking, obesity, sedentary behavior, low vegetable or fruit intake. They found that young women and men, ages 18 to 24, had poor health profiles and experienced adverse changes from 1990 to 2000. After the variables were adjusted for education and income,

these young people had the highest prevalence of smoking (34%-36% current smokers among white women and men), the largest increases in smoking (10%-12% increase among white women and men; 9% increase among Hispanic women), and large increases in obesity (4%-9% increase, all gender and racial/ethnic groups). Young women and men from each racial/ethnic group also had high levels of sedentary behavior (approximately 20%-30%) and low vegetable or fruit intake (approximately 35%-50%). In contrast, older Hispanic women and men and older black men, ages 65 to 74, showed some of the most positive changes. They had the largest decreases in smoking (Hispanic women), largest decreases in sedentary behavior (Hispanic women and black men), and largest increases in vegetable or fruit intake (Hispanic women and men, and black men). The results of this study suggest that as individuals enter the ages of high chronic disease burden they are more likely to change behavior (Winkleby & Cubbin, 2004).

1.3.2 Education

Black-white differences in education are rooted in historical inequalities for basic opportunities to obtain an education; and therefore, to compare educational attainment differences among Blacks and whites outside of this historical context is extremely problematic (Farley & Allen, 1987), especially for Black elderly who have faced higher levels of overt racism in education than their younger counterparts. Taeuber (1992) describes elderly Black Americans as having much lower levels of educational attainment than their white counterparts. Elderly whites are much more likely than elderly Blacks to have graduated from high school (57.9% vs. 24.6%) and college (11.7% vs. 4.6%). Over half of all elderly Blacks (57.3%) have completed less than 9 years of formal education (Taeuber, 1992). Relatively high percentages of elderly Blacks can be classified as functionally illiterate, that is completing no more than 4 years of elementary school

(Siegel, 1993). Having a literate spouse may help mitigate the impact of functional illiteracy to some degree. However, many illiterate elderly Black men and most illiterate elderly Black women do not have a spouse. Literacy rates are expected to rapidly improve as younger more literate cohorts of Blacks become elderly (Siegel, 1993). Siegel (1993) reports that persons who are functionally illiterate have some of the highest levels of poverty, have high rates of unemployment over their life span, experience extreme difficulty in the ability to read and follow instructions on medications, have lower levels of voting, and are disproportionately victims of consumer fraud. The limited ability to read and write poses serious barriers for older adults attempting or needing to access formal social and health services.

"Health literacy is the degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions. But health literacy goes beyond the individual. It also depends upon the skills, preferences, and expectations of health information and care providers: our doctors; nurses; administrators; home health workers; the media; and many others" (Institute of Medicine, 2004). Nearly half of all American adults – 90 million -- have difficulty understanding and acting upon health information (Kirsch, Jungeblut, Jenkins, & Kolstad, 1993). In 1992, the Department of Education conducted the NALS (National Adult Literacy Survey) with over 26,000 individuals, aged 16 and over. Proficiency scores were calculated on three scales: prose, document and quantitative literacy. NALS results suggest that 21 to 23 percent, or about 20 percent of the total population, demonstrated skills in the lowest level (Level 1) of prose, document and quantitative literacy. Results are alarming for at-risk and vulnerable populations. For example, among adults who have not completed high school, almost half scored at or below the lowest literacy level. Similarly, almost half of adults over the age of 65 performed at or below the lowest level.

Minority populations, including adults born outside the United States, scored significantly below white adults and adults born in the United States, on average (Kirsch et al., 1993). As a result of this national study, several analyses have been conducted, producing reports with a particular focus on the relationship between health literacy and health status, especially among vulnerable populations.

For example, Brown, Pristuta, Jacobs and Campbell (1996) found that skill levels differ by income and many older adults do not believe they have a problem with literacy. Roberts & Fawcett (1998) conclude that many health problems faced by elders are exacerbated by low literacy skills. Rudd, Kirsch, & Yamamoto (2004) argue that literacy is one of the major factors linking health and education and it contributes to existing disparities in health status, access to care and the quality of health care for many individuals (Rudd, Kirsch, & Yamamoto, 2004).

1.3.3 Income

Economic status in older age is a product of a lifetime of economic experiences, including earnings, savings, and participating in pension, health insurance, and public assistance plans. Economic advantages and disadvantages that accumulate throughout the life course produce significant differences in the economic status of older persons. Earlier studies (Gibson, 1993, 1982; Jackson & Gibson, 1985) illustrate that the work histories and retirement patterns of Blacks and Whites are drastically different.

More recently, the Family Economics and Nutrition Review **(**1998) indicated that "women's economic histories strongly predict their financial circumstances at age 62 or older" (p. 3), and offered two types of explanations for high poverty among aged women: (1) living conditions or personal characteristics and (2) particular events that are linked to the onset of

poverty later in life, including loss of earnings, widowhood, or declining health. Knowing the origins of poverty allows the creation of more appropriate policies to address it.

Economic status carries over into other aspects of daily life, often times impinging upon health (David & Collins, 1991). Leigh and Lindquist reported that Black women, like all women, receive health care in the context of their multiple caregiving roles—as wives, mothers, daughters, widows, single childless women, and so on. Prejudice, discrimination, and poverty all contribute to daily stressors that affect women's health (Leigh & Linquist, 1995). Additionally, economic status may play a role in health behavior and preventive care. For example, in their study on self-care, Becker et al (2004) found regular exercise was reported less often by persons who were uninsured; and those who were insured had more opportunities to discuss their chronic conditions with health care providers and receive advice on particular health behaviors to reduce health risks. In contrast, those who were uninsured were often left to their own 'devices' in regards to preventing disease and managing conditions they already had (Becker, Gates, Newsom, 2004).

Poverty is also a key determinant of living arrangements (Lacayo & Carmela, 1991). Many minority elderly have struggled for years to keep up their houses, pay property taxes, and make mortgage or rent payments, because of a history of low paying jobs resulting in no retirement pensions. They have also been the victims of housing discrimination and 'red-lining' by lending institutions, both limiting their housing options and they often lack extended family with whom to live (Lacayo & Carmela, 1991).

1.3.4 Marital Status/Living Arrangement

Marital status and living arrangements are closely linked to income, health status, and the availability of caregivers and thus are important factors for older adults. Marital status can strongly affect a person's emotional and economic well-being by influencing living arrangements and caregiver availability; older adults living alone are more likely to be in poverty (Forum, 2000).

A study by Sven Wilson (2001) illustrates the relationship between marital status and health status. Wilson examined the association between socioeconomic status (SES) and the prevalence of mutually occurring health problems among married couples in late midlife, using two health measures: (1) self-assessed health status and (2) functional limitations and activity restrictions. After adjusting for age, he found an association between the health of one spouse and the other. SES was highly associated with the joint occurrence of health problems among marriage partners. Marital status has been shown to be a strong correlate of morbidity and disability in previous studies (Goldman, Korenman, Weinstein, 1995; Wyke, 1992). Both married men and married women consistently have better health than their unmarried counterparts and for an individual in poor health, a spouse is the most likely caregiver (Allen, Goldsheider, Ciambrone, 1999). For example, married, older African-American women are more likely to get preventive health screenings (Hunter, Bernard, Payne-Wilks, Roland, Elam, Feng, & Levine, 2002, p. 535).

Finally, older women are at great risk of becoming isolated if they do not have access to community or other supportive services and if they develop chronic ailments or become disabled or frail (AOA, 2003). Widowhood often leaves them living alone; disabling and chronic illness often makes them dependent and unable to socialize and participate in routine activities. All of

these scenarios can lead to isolation, depression, and increased poverty. Combined, these risks create significant health issues for older women.

1.4 BIAS AND INEQUALITY IN HEALTH CARE

Any effort to understand the constraints in health-related behavior must take into account the social and cultural context of individuals (Cain & Kingston, 2003). According to Braithwaite and Taylor (2000), recent research on aging and discriminated-against minorities has focused on three major themes – heterogeneity, vulnerabilities due to societal maltreatment, and family strengths. These three themes are especially relevant for older African Americans (Tucker, 2000). Their past history, including racial inequality, socioeconomic disparities, and individual and group coping resources, influences their morbidity, family and community relationships as well as their morbidity and mortality (Braithwaite & Taylor, 2000). "Racism has been, and continues to be, a major contributor to the poor health of Black Americans" (Byrd & Clayton, 2003, p. 456). The Institute of Medicine report (Smedley et al., 2003) documented several studies demonstrating widespread racism in healthcare. According to the report, potential sources of disparities in care include:

- Patient-level factors – including patient preferences, refusal of treatment, poor adherence, biological differences;
- Disparities arising from the clinical encounter; and
- Health systems-level factors – financing, structure of care; cultural and linguistic barriers.

The report indicated that disparities in care are consistently found: (a) across a wide range of disease areas and clinical services; (b) even when clinical factors, such as stage of disease presentation, co-morbidities, age, and severity of disease are taken into account; (c) across a range of clinical settings, including public and private hospitals, teaching and non-teaching hospitals, etc.; and (d) are associated with higher mortality among minorities (Smedley et al., 2003). The IOM report (Smedley et al., 2003) illustrates the long existing health gap between minority and non-minority Americans, which has persisted, and, in some cases, has increased in recent years.

Reducing or eliminating the disparities in health found among various racial/ethnic groups in the U.S. has become a priority of the National Institutes of Health and the Department of Health and Human Services. Even with new technologies and advanced knowledge, health disparities continue to grow (AHRQ, 2002).

Mandelblatt, et. al (1992) examined health beliefs and practices related to mammography and gynecological exams. Four-hundred and forty-five women (94%) consented to be interviewed; 74% reported a mammogram, and 85% reported a Papanicolaou (pap) smear in the past, although these early-detection tests were not obtained with any regularity after age 65. Concordance between self-reported screening use and blind chart review was more than 90%. The major reasons for non-use of both screening tests were that a physician hadn't recommended them or that the women didn't know they needed them. Levels of knowledge about breast and cervical cancer were low; 68% believed bumping or bruising the breast caused cancer, and only 25% knew that cancer risk increased with advancing age (Mandelblatt, Traxler, Lakin, Kanetsky, & Kao, 1992).

Escarce, Epstein, Colby, and Schwartz (1993) examined racial differences in the use of 32 medical procedures and diagnostic tests among a group of older Americans. For each service, they calculated the age- and sex-adjusted rate of use by race and the corresponding White-Black relative risk. Whites were more likely than Blacks to receive 23 services and, for many of these services, the differences were substantial. According to the authors, income was not a factor, as racial differences in use persisted among elders who had Medicaid in addition to Medicare coverage. There were pervasive racial differences that could not be explained by differences in the prevalence of the health conditions.

Ayanian, Weissman, Taber, and Epstein (1999) found that Black Medicare patients hospitalized for heart failure or pneumonia in three large states received poorer overall quality of care than other Medicare patients treated for the same illnesses. Racial disparities occurred even in basic hospital services, such as physical exams, simple diagnostic tests, standard drug therapies, and patient history-taking. The researchers found that quality of care differences for Black heart failure patients tended to be more pronounced in community hospitals than in teaching facilities. Although prompt administration of antibiotics and collection of blood cultures have been associated with lower mortality rates in prior research, Ayanian et al. (1999) found that only 32% of the Black pneumonia patients were given antibiotics within 6 hours of admission, compared to 53% of the other Medicare patients being treated for the same condition.

Black patients were also less likely to have had their blood cultures collected on the first or second day of hospitalization (Ayanian et al., 1999). Rathore et al. (2000) evaluated 169,079 Medicare beneficiaries 65 years of age and older, who were treated for acute myocardial infarction (AMI) between January 1994 and February 1996, to determine the association of patient race, sex, and poverty with the use of medical therapy. The findings revealed that Black

patients were less likely than Whites to undergo reperfusion or receive aspirin on admission and beta-blockers at discharge. Female patients were less likely than male patients to receive aspirin at admission and discharge. Poor patients were less likely than those better off financially to receive aspirin or reperfusion on admission and aspirin or beta-blockers on discharge (Rathore et al., 2000).

Researchers at Georgetown University's Lombardi Cancer Center, and their colleagues at 29 hospitals across the country, investigated 718 breast cancer patients age 67 and older who were diagnosed with localized disease between 1995 and 1997 (Madelblatt, Hadley, & Kerner, 2000). Older women's preferences were found to be important in determining treatment and patient-physician communication focused on patient concerns, influenced patient selection of therapies and satisfaction with treatment (Mandelblatt et al., 2000). However, women 80 years and older were less likely to be referred to a radiation oncologist, and after breast conserving therapy, they were more than three times as likely not to receive radiation therapy (Mandelblatt et al, 2000). Yet, according to AHRQ (2002), the risk of cancer recurrence approaches 40% within 10 years when radiation is not given after lumpectomy. This timeframe is well within the life expectancy of older women.

Marbella and Layde (2001) examined trends in race and age specific patterns of breast cancer mortality by analyzing data from 1979-1996. From 1993-1996 White women of all age groups experienced, on average, an annual decrease in breast cancer mortality. Throughout the study period, young Black women had higher rates of breast cancer mortality than young White women. Older Black women had lower mortality rates than older White women in earlier years of the study but experienced higher rates in later years – 1993-1996. Marbella and Layde (2001) concluded that trends in risk factors and early detection did not provide an adequate explanation

for the more recent substantial increase in breast cancer mortality among older Black women. Rather, they suggested that more research is needed to understand more fully the breast cancer rate differences between the races to determine whether changes in public health policy or clinical practice can decrease the racial disparity in breast cancer mortality rate.

According to a recent Surgeon General's report, disparities in care exist for treatment of mental health problems as well as for services for physical ailments. Mental health disparities include gaps in access, questionable diagnostic practices, and limited provision of optimum treatment (U.S. DHHS, 2001). Snowden (2003) argued that there may be more reason for concern about bias in mental health than any other area of health because of the stigma, mistrust, misdiagnosis and myths associated with mental health. Other research has revealed several interesting findings that support Snowden's view. For example, injectable drugs are more often given to African Americans (Citrone, Levine & Allingham, 1996). Kuno and Ruthbard (1997) found that African Americans were less likely than Whites to receive newer, atypical antipsychotic drugs that had fewer side effects and, instead, were more likely to receive injectable drugs. Another study (Alvarez, 1999) indicated that African American women were more likely than White women to affirm religious or supernatural causes of mental illness. Elderly community residents and Medicaid recipients, in general, are relatively unlikely to be given antidepressants (Blazer, Hybel, Simonsick, & Hanlon, 2000). Diala, Muntaner, Walrath, Nickerson, LaVeist, and Leaf (2000), analyzing data from the National Co-morbidity Study, found that prior to using mental health services, African Americans had a favorable attitude about them and a less favorable attitude after using them. When sought, assistance for mental health problems is likely to be through primary care physicians (Snowden & Pingatore, 2002). In addition, when African Americans are given drugs, they are given suspiciously higher doses

(Snowden, 2003). Although bias has been identified as a major issue related to African Americans and mental health, there are also individual, cultural, community, provider, and socio-economic barriers that influence or inhibit one's seeking and responding to mental health services and treatment (Snowden, 2003).

Other research has indicated that the elderly may experience more pain than younger people (Corran, Gibson, Farrell, & Helme, 1994), although they may be less likely to complain about it (Melding, 1991). Some believe that elderly cancer patients may be reluctant to report their pain, often viewing it as an expected concomitant of aging (Bernabei et al., 1998); however, earlier research indicates that there is a relationship between pain and depression which suggests that elderly patients with depression are more sensitive to pain caused by the coexisting physical condition (Parmalee, Katz, & Lawton, 1989).

In a study of more than 4,000 cancer patients Bernabei et al. (1998) found that age, gender, race, marital status, physical function, depression and cognitive skills were all independently associated with the presence of pain. Elderly and minority cancer patients may receive inadequate analgesia in part due to an underestimation or underreporting of pain. Findings indicated that patients from racial and ethnic minority groups were less likely than Whites to have pain recorded; there was a strong inverse correlation between the presence of pain and increasing age; there was an equally strong relationship between pain and belonging to a minority group (Bernabei, et al, 1998).

1.5 PERCEPTIONS OF CARE

According to Chrisman (1977), past experiences and perceptions of those experiences can influence individuals' current and future health-related behaviors. This section, therefore, presents what is known about the perceptions of African Americans towards the health care system.

Becker and Newsome (2003) found distinct differences between how 111 middle-income and low-income African Americans, aged 21 to 63 with one or more chronic conditions, perceived their experiences with the health care system. Low-income persons were infrequently seen for routine checkups compared with middle-income persons. Routine checkups not only serve as a primary teaching opportunity for helping patients understand and manage their health; they also facilitate building rapport between patient and practitioner. Low-income respondents had many complaints about their health care, while middle-income respondents had few.

According to the researchers, low-income patients expressed great frustration in dealing with the health care system and this experience apparently affected their interactions with individual providers (Becker & Newsome, 2003). Many low-income patients received care in public hospitals or clinics, and therefore had no regular doctor, or saw physicians 'in training.' As a result they were reluctant to form bonds with changing physicians, and this also led to their increased suspicion and mistrust of practitioners' skills and intentions. Becker and Newsome (2003) found that when medications did not correct the presenting problem, the low-income respondents questioned physician knowledge and this became a deterrent to seeking care unless absolutely necessary.

Johnson, Roter, Rowe, and Cooper (2004) examined communication between patients and health providers. Research assistants recruited patients in the waiting room of 51 physicians

(30 White, 21 African American), half of whom reported having had some communication skills training. Results revealed that physicians were more verbally dominant and tended to be less patient centered in their approach with African American patients than with White patients. These differences remained statistically significant even after adjusting for patient and physician demographic characteristics and how well the physicians knew the patient. Johnson et al. (2004) suggested that while overall time spent with patients is important, patient engagement and participation during medical visits may be contributing to health disparities.

1.6 HEALTH STATUS

Minorities experience higher rates of chronic and disabling illnesses, infectious diseases, and mortality than White Americans (Smedley et al., 2003). Compared to Whites, Blacks have more undetected diseases, higher disease and illness rates, more chronic conditions, and shorter life expectancies (National Center for Health Statistics, 2000). Many experts have sought explanations for racial differences in health status and many contributing factors have been identified. These factors include unequal treatment, lack of health insurance, frequency of care, access to care, and stereotyping (Byrd, Clayton, 2003).

African Americans are one and a half times more likely than Whites to lack health insurance, which translates into disparities in access to health care services and often disparities in health status (UCLA & Kaiser, 2000). Having health insurance provides access to a range of covered preventive services. Preventive screenings and early detection – or the lack of them -- can affect health status later in life. Without access to and regular use of health care services, it is unlikely that conditions such as these and others will be diagnosed and managed effectively

since health insurance coverage often predicts the use of preventive services and screenings (UCLA & Kaiser, 2000). There is evidence that early diagnosis of life-threatening illnesses can lead to earlier treatment and better health status. Although many factors affect health status, regular medical care increases the opportunities for individuals to access screenings and care for such diseases as breast, prostate, and cervical cancer.

Franks, Gold and Fiscella (2003) analyzed data from a nationally representative sample of 21,363 persons aged 21 and over and found that greater income and education were associated with better health. Compared with Whites, Blacks reported worse health. After adjusting for baseline self-rated health, the relationships between income and educated were greatly attenuated, whereas the relationship between age, gender, race/ethnicity and mortality were not. They concluded also that lower socioeconomic status (SES) and being Black were associated with lower self-reported health status and higher mortality; women reported lower self-rated health status but exhibited lower mortality. The effects of SES on mortality were largely explained by their associations with self-rated health, whereas the effects of gender and race/ethnicity on mortality appear to act through independent pathways (Franks, Gold, & Fiscella, 2003).

Race/ethnicity, education and income affect the health status of Medicare – insured older women (AHRQ, 2002). Minority women continue to fare worse than White women in terms of health status, rates of disability, and mortality and they bear a disproportionate burden of morbidity and mortality from a wide range of health problems, including heart disease, lung cancer, breast cancer, diabetes, HIV/AIDS, and suicide (Leigh & Linquist, 1996-1997).

1.7 RELEVANCE OF CURRENT STUDY TO SOCIAL WORK

Almost a century ago, pioneering African American social workers advocated for the social work profession to view the Black experience as a unique historical and cultural entity (Martin & Martin, 1995). Social workers who are members of geriatric interdisciplinary teams should be aware of the health-seeking, health-related beliefs, and practices of older African Americans. It is important for social workers to partner with public health agencies to educate older adults and their social networks on these issues as they relate to health promotion and disease prevention (Bertera, 2003). This understanding will allow us to reinforce the 'help' that is available through our client's informal system and complement it with other existing resources they may not be able to access on their own.

Greene (1995) argued that social workers conceptualize their involvement with clients by emphasizing the client's individual characteristics or problems in communicating with others. However, according to Greene (1995), more attention must be given to understanding the client's cultural background, finding ways to translate cultural understanding into improved social, health, and counseling practices, and considering the larger cultural settings in which family life and social networks are embedded. Greene (1995) suggested that social workers need a better understanding of how people in ethnic and minority communities think about their needs and how they act to meet them.

Understanding how individuals make decisions about their health and social well-being, and the basis for those decisions, can inform social work practice. Knowledge of the social and cultural influences on our clients' beliefs, perceptions, and practices, will allow us to better understand how these contribute to current racial and ethnic disparities in health and health-seeking.

The National Association of Social Work (NASW) reported that 21% of its 155,000 members were employed in health care and public health settings during the late 90's, making health and public health second to mental health and clinical social work as a source of employment for our profession (Volland, Berkman, Stein & Vaghy, 1999). The practice of Public Health Social Work draws not only upon social and behavioral theories and concepts (Florida State Department of Health, 2000), but also upon the core functions of public health: assessment, policy development and planning, and assurance (IOM, 1988). Public Health Social Workers are an integral part of the inter-disciplinary public health team because they bring a unique focus on psychosocial factors that impact health (Florida State Department of Health, 2000).

Social workers can use the findings from this research to gain a better understanding of the health behavior of older Black women as described by the women themselves. It is my hope that this dissertation w/ill contribute to the knowledge base of social work practice with older adult populations.

2.0 CONCEPTUAL FRAMEWORK.

Chrisman (1977) defined health-seeking behavior as the steps taken by an individual who perceives a need for help as he or she attempts to solve a health problem. The Chrisman model includes five components: symptom definition, illness-shifts in role behavior, lay consultation, treatment actions and adherence. The model is rooted in the earlier work done by such scholars as Fabrega and Roberts (1973), Becker (1974), Kleinman (1975) and others. It is grounded in the Health Belief Model (HBM) (Glanz, Lewis, & Rimer, 1997), which was first developed in the 1950's by a group of social psychologists in the U.S. Public Health Service. The HBM initially focused on issues related to screening and compliance to explain the widespread failure of people to participate in programs designed to prevent or to detect disease. Over the years it has been used much more broadly and in multiple disease areas (Glanz, Lewis, & Rimer, 1997). While the HBM has been an effective model for understanding health behavior, the Chrisman model builds on the HBM by also addressing the social and cultural aspects of health behavior. In this chapter, I discuss the key points of the Chrisman health-seeking model, which provides the organizing framework for this study.

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2.1 CHRISMAN HEALTH-SEEKING BEHAVIOR

Much of the literature on health- or help-seeking behavior (e.g., Chrisman, 1977; Eisenberg, 1980; Greene, 1995; Kleinman, 1978; Neighbors, 1984; Spector, 1996) suggests a process that an individual goes through in response to an illness or health-related problem or concern. Chrisman (1977) introduced a health-seeking process as a comprehensive scheme for examining a person's reaction to sickness or symptoms. The Chrisman model is an attempt to conceptualize a person's experiences with sickness holistically as a natural history of illness (Chrisman, 1977). The Chrisman model provides a very simple and clear process that incorporates the significance of culture, cultural influences, and intra-group communication into a person's reaction to illness. According to Chrisman (1977), health behaviors are determined by the degree of threat disability or danger one feels when facing a problem. He defined disability as the degree to which behaviors of life are inhibited by symptoms; danger is more closely related to the meaning of symptoms and is therefore more culturally based (Chrisman, 1977).

The Chrisman model (1977) describes steps taken by an individual who perceives a need for help as he or she attempts to solve a health problem. These steps include: (a) symptom definition, (b) illness-related shifts in role behavior, (c) lay consultation and referral, (d) treatment actions, and (e) adherence. Each of these elements involves health-related actions that a sick person may exhibit during a chronic illness. However, the steps in the process are not necessarily sequential and some elements may even be skipped.

2.1.1 Symptom Definition

Chrisman (1977) indicated that the nature and quality of perceived changes in health status are major determinants of subsequent health-related actions. The concept of symptom definition is drawn from the literature on illness behavior (Fabrega, 1973; Kasl & Cobb, 1966; Mechanic, 1962; Twaddle, 1969). Illness behavior refers to the ways in which given symptoms are perceived, evaluated, and acted (or not acted) upon by different people (Mechanic, 1969). People develop culturally-based explanatory models of their illness, as Kleinman would call it, applying meaning to the experience (as cited in Green, 1995, p. 63), and all cultures provide explanations to which suffering individuals can turn for relief (Green, 1995).

Fabrega (1973) described symptom definition as an information processing sequence. Although subsequent events in the health-seeking process continue to depend upon individual data processing, individuals in one's social environment start to become significant at this point (Chrisman, 1977). What Chrisman characterizes as lay consultation and referral relates to those health messages and health messengers, as mentioned in Chapter 1. For example, friends, family members, and others in an individual's social or informal network have opinions and beliefs that they offer; the individual might also seek information and advice from various trusted sources. These members of the social or informal network can also play a role in assisting the individual in maintaining his or her role behavior, responsibilities, or routine activities. The individual might give new attention to health messages not previously noticed.

Over the years, there has been research examining various aspects of symptom definitions and cues to action in response to a health problem. Battistella (1971) examined the delay in initiation of physician's care for illness in a general sample of respondents aged 45 and over. He examined (a) social-structural characteristics (economic status, social status, and social

isolation) and (b) social-psychological characteristics (perceived chances of recovery from serious illness, and worry over health). Basttistella found a slight patterning in the data that suggested that middle-aged persons aged 45 to 59 delayed seeking care less than older persons. The pattern of delay increased in the 60 to 69 age group and increased even more in the 70 and over age group. Contrary to some other studies, Basttistella reported no evidence to suggest that persons of lower economic status delayed initiating care longer than those of higher economic status.

Eisenberg (1980) suggested that on the way to becoming a patient, an individual must make, almost always with the participation of significant others, a self-diagnosis that she or he is ill. Such a judgment is made against implicit standards of what it is meant to be well. Wellness is subjective, meaning different things to different people: feeling good, not having symptoms, being able to get one's job done, not believing oneself to be vulnerable, and/or being told by the doctor that one is well (Eisenberg, 1980). Thus, how symptoms are defined and interpreted can influence one's initiation of health care.

Anson, Paran, Neumann, and Chernichovsky (1993) examined gender differences in health perceptions and found that there were clear differences in the subjective evaluation of health and symptom perceptions. Anson et al. (1993) found that over twice as many women as men evaluated their health as poor; on the average, women reported experiencing 2.6 symptoms more than men. While this may, in part, reflect the fact that women on average live longer than men, although not always in good health, it also may explain why women are overrepresented in the health care system.

2.1.2 Illness-Related Shifts in Role Behavior

Shifts in role behavior can occur when an ill person's health status is brought to the attention of families, friends and others who become involved in the events of the illness episode. Frequently this occurs as a part of the negotiation process related to a person's inability to fulfill his or her social obligations because of an illness-based restriction. The shift in role behavior is generally determined by the illness severity and/or its relationship to the person's life style. Both social and cultural features of the sick role must be examined. These features include the range of daily life behaviors, their definitions, and the cultural importance placed upon them (Chrisman, 1977).

According to Eisenberg (1980), the transition from person to patient and back represents social decision points. An individual's other social identities, and his or her accompanying rights and obligations, influence the way a person carries out any specific role. For example, a father who has the position of a factory worker may carry out the father role differently from the father who is a doctor or corporate executive (Chrisman, 1977). Thus, these fathers may respond differently to illness and the decision to shift their role behavior and/or take time off from work due to illness. Eisenberg (1980) posited that medical care will be improved if the clinician, in assessing patient problems, systematically inquires into the social determinants of the decision to seek help.

2.1.3 Lay Consultation and Referral

The notion of lay consultation and referral refers to an individual seeking aid in identifying an illness, asking for suggestions about treatment, and eliciting recommendations of competent

help. It implies the existence of shared health beliefs and practices. It is an interactive process occurring between an individual and those consulted that determines whether or not a practitioner is consulted. The cultural context of health beliefs and practices are a central aspect of symptom definition, the lay referral process, and treatment action (Chrisman, 1977). In other words, a person seeking advice regarding a particular illness generally asks someone who shares similar health beliefs and who can influence the person's decision.

Research into illness behavior and heath behavior has shown that decision making about health and when to seek medical care, entails a social process involving at least one other person apart from the sufferer (Calnan, 1983; Robinson, 1971; Suchman, 1966). The referral system is used more frequently with friends than family (McKinlay, 1973; Salloway, 1973).

Calnan (1983) examined the patterns of 628 patients who attended a hospital emergency department attached to district general hospital. The patients, who were identified from around-the-clock admissions over a 12 month period, were interviewed at home as soon as possible after leaving the hospital. The ages of the patients ranged from 5 years to over 65 years. Overall, 81% of the adult patients and the informants for patients under the age of 16 reported having contact with at least one other person throughout the whole process of deciding to seek medical care. The most frequent contacts were family members (18%) and friends or neighbors (15%). Seventeen percent (17%) made formal contacts with police, employers, teachers, and others with some training in first aid or medicine, such as off-duty nurses. Further, 6% contacted strangers or bystanders, and 4% contacted coworkers. The results also showed that the decision to seek medical care was made within three hours of the onset of the trouble in 55% of the cases; in 35% of the cases the delay in seeking care was for more than three hours. Calnan found that variation

in the urgency with which medical attention was sought was based on the perceived seriousness of the problem and on the status of the person who advised the sufferer.

2.1.4 Treatment Actions

Treatment actions are behaviors in which individuals engage in as an attempt to cure or reduce the impact of their health problem. Such actions include four basic categories**:** activity alteration, ingestion or injection of a substance, verbal or ritual behaviors, and physical interventions on the body. Sources and advice about treatment actions generally include formal health professionals, licensed health practitioners, alternative or natural health practitioners, lay consultants, and self (Chrisman, 1977).

Self-care in the health context can mean: (1) individual lifestyle practices that promote health seeking and disease prevention behaviors, or (2) self-treatment, without professional intervention, to deal with bodily changes or symptoms of apparent illness (Wykle & Haug, 1993). Personal decision making and interaction with professional providers are important aspects of self-care behavior, and because most medical contacts are preceded and followed by self-treatments, the continuum of formal care and self-care aspects of decisions to seek help cannot be ignored (Dean, 1981).

There are many reasons why an individual may engage in treatment actions that do not include formal health providers. Nuttbrock and Kosberg (1980) suggested that one overlooked influence on the decision to seek professional help is the doctor. These authors stated that a significant proportion of the elderly are, for one reason or another, dissatisfied with and skeptical of physicians and professional medicine (Nuttbrock & Kosberg, 1980). Their negative perceptions of medical providers may contribute to their delaying the initiation of care.

2.1.5 Adherence

Adherence is the degree to which the sick person acts upon advice received. Doctor-patient communication is a major variable influencing adherence. Culture, race, and ethnicity influence clinical relationships, treatment compliance, and, ultimately, the recovery from illness (Chrisman, 1977). To achieve adherence with medical treatment, cultural sensitivity is a prerequisite (Carter, 1995). For example, many providers are unaware that African Americans may continue to use prescribed medicine and home remedies simultaneously. Often times, patients believe that adherence with biomedical treatment does not require discontinuing home remedies even though the combination may be counteractive (Carter, 1990).

Nuttbrock and Kosberg (1980) analyzed data collected from 122 older respondents. They found that attitudes related to the technical aspects of medicine or physician performance were not significant in terms of help-seeking. However, a perception of one's physician as a person interested in one's welfare as a patient was a significant predictor of both the inclination to and actual behavior of seeking medical help and following treatment plans.

Eisenberg (1980) stated that the probability of resolving a patient's difficulty would be enhanced by targeting treatment at the social components of the illness experience as well as at the patho-physiology of the disease process. Therefore, it is extremely important for the provider to understand the social context surrounding the person=s decision to see the doctor. This is indispensable to diagnosis and treatment. Eisenberg further proposed that the appropriate model for medical consultation should be seen as process of negotiation between the perspectives of the doctor and the patient in order for them to work together cooperatively toward common objectives. This type of negotiation would require a better understanding on the part of the provider of the patient's health beliefs, practices, and treatment actions.

2.2 SUMMARY

Why individuals act as they do has been a focus of inquiry for decades. Developing an understanding of health-related behavior and the decisions individuals make about their health status and health-seeking options has gained prominence in recent years. Yet, the decision making processes of older, African American women regarding their health have remained an understudied area.

Chrisman (1977) proposed a model to characterize how people respond to instances of acute illness. He subsequently applied this model to chronic conditions. As described in this chapter, Chrisman's model identifies five concepts – symptom definition, illness related shifts in role behavior, lay consultation and referral, treatment actions, and adherence – that provide a useful framework for looking at how older, African American women perceive, describe, and respond to their health needs. As will be discussed more fully in later chapters, these five concepts served as the analytic framework for this qualitative analysis.

3.0 THE BLACK HELPING EXPERIENCE: TRADITIONS AND NORMS

McInnis-Ditrich (2002) described aging as the last stage in a series of life stages that comprise the life course. Accordingly, differences in the way older adults adjust or adapt to the physical changes of aging are due to a variety of factors, including genetic pre-disposition to certain physical ailments, general lifetime health status, and most important, the influence of lifestyle choices, including nutrition and physical activity (McInnis-Ditrich 2002). In addition, social and cultural forces play important roles in influencing older adults' beliefs, perceptions, and behaviors. In this chapter, I provide a brief review of the history and literature regarding the Black helping experience, and discuss its implications for older Black women's health behaviors.

3.1 CULTURAL TRADITIONS AND NORMS

There is often a fundamental difference between the beliefs of the consumer and the provider (Spector, 1996). The consumer's beliefs and perceptions about the nature of the problem, what caused it, and how it can be resolved, are influenced by historical experiences and cultural traditions. Many of the preventive and treatment practices of African Americans have their roots in both the African and Native American cultures (Spector, 1996). Understanding the history

and tradition of helping in Black families and the roles culture, tradition, religion, and spirituality play in seeking help is quite useful when examining the health beliefs and behaviors of African Americans.

3.1.1 Health, Spirituality and Religion

Williams (1993) described spirituality for Black women in America as being cemented in slavery, with its attempt to destroy the African culture, its sexual abuse of Black women, and its separation of families. Spirituality provided hope and, in spite of these hardships, enslaved women were able to transcend and transform their experiences through their faith. The presence of God was affirmed in their struggles and they embraced religious experience in response to their losses and sorrow (Collins, 1991). God was perceived as a deliverer from unjust suffering and the comforter in troubled times; prayer and specific beliefs about God and the meaning of life were incorporated into the coping efforts of Black women (Eugene, 1995).

Spirituality has been identified as a basic or an inherent quality of all humans. Spirituality is relative to each individual in the way in which they define it. It refers to an inner quality that facilitates connectedness of self, others, and nature and a belief in something greater than the self (Millier, 1995). Spirituality is associated with positive health outcomes for women and has been associated with improved perceptions of health status, increased rates of mammography testing, and the ability to withstand poverty or a positive diagnosis of HIV (Musgrave, Allen, & Allen, 2002).

Religiosity, on the other hand, refers to religious practice, church attendance, or participation in religious activities (Gibson, 1982; Millier, 1995). Many people identify with

spirituality without having a religious affiliation (Musgrave et al., 2002). However, together, spirituality and religiosity provide a framework for coping with the world and making sense of life (Millier, 1995), and this framework provides an opportunity for public health intervention (Musgrave, et al., 2002).

Research supports the importance of religious participation in the lives of Blacks, who are more likely than Whites to pray privately, practice religious rituals, attend religious services, and believe that the Bible is the word of God (Jacobson, Heaton, Dennis, 1990; Johnson, Matre, Armbrecht, 1991). An examination of racial differences indicates that Black elderly demonstrate higher levels of religious participation than their White counterparts (Taylor & Chatters, 1991). Work by Taylor, Chatters and others (Chatters, Levine, & Taylor, 1992; Levine & Taylor, 1993; Taylor & Chatters, 1986; Taylor & Lockery, 1995) has investigated the correlates of religious involvement using data from the National Survey of Black Americans. These studies indicated both a significant degree of religious involvement and substantial heterogeneity in religious participation among Blacks. According to these authors, Black adults, in general, and older adults, in particular, are frequent church attendee's, have high rates of church membership, have a high likelihood of characterizing themselves as religious, and are extensively involved in private religious activities such as prayer, reading religious materials, watching religious programs on TV or listening to them on the radio.

Historically, the church has been a central institution in the Black community. Throughout the 20th century, the church has promoted education, business, and political activism within the Black community ((Brown & Gary, 1994; Lincoln & Mamiya, 1990; Nelsen & Nelsen, 1975). Black churches have played a major role in the cultural development and

survival of African American communities, serving as the center of social networks (Markens, Fox, Taub, & Gilbert, 2002).

The Black church has served a critical role in the lives of Black women and they have felt free to experience the power of the Spirit as a healing resource (Baker-Fletcher, 1998). Prayer, the bible, and the church community are the resources that religious Black women use to meet daily needs (Millier, 1995). Religiosity and spirituality have emerged as critical factors in Black women's efforts to understand, interpret, and cope with adversity (Mattis, 1995; McAdoo, 1992). The Black church offers an outlet for pent-up anguish through the expression of emotion; women become therapists to each other with the church assuming the role of an "asylum of therapeutic assistance" as well as a place of shelter (Eugene as cited in Musgrave, 2002, p.558).

Yet despite the high levels of religious involvement, there is also great heterogeneity in the extent of that involvement. Age, gender, region, marital status, socioeconomic status, and urban city influenced religious involvement (Chatters, Levine & Taylor, 1992). Chatters et al. (1992) reported that women, older persons, individuals with higher socio-economic status, rural respondents, and Southerners display a greater degree of religious involvement than their counterparts. They also found that of these factors, age and gender differences were the strongest and most consistent predictors of religious involvement.

As it relates to church-based informal support networks, two out of three adults indicated that the church provided some level of informal support to them. Church attendance, membership, church affiliation, and subjective religiosity were all found to be significantly related to receiving informal support (Taylor & Lockery, 1995). Ellison (1998) reported that a growing body of evidence links African Americans' religious involvement with positive self-

perception, positive self-esteem, a sense of control over one's affairs, coping, positive physical and mental health, and a reduction in mortality risks.

Churches have become the focus of health-related interventions for hypertension, smoking cessation, and heart disease (Hatch & Voorhorst, 1992). Yet, there may be limits to the role of the church. Markens et al. (2002) assessed pastor-level factors that influence the successful recruitment and implementation of community-based health promotion programs in the church. They found that often times pastors are over-committed to other issues related to their role as pastor and this can negatively affect their ability to participate. In addition, although Black pastors appreciated being included in and benefiting from health research, they had concerns about exploitation and were suspicious and reluctant to participate (Markens et al., 2002). While the Black church provides an opportunity for both social work and public health partnerships, respect for the central mission of the faith institution must be respected (Musgrave et al., 2002).

3.1.2 Exchange and Caregiving

Historically, Black families have functioned in a pattern of exchange (Martin & Martin, 1985). This helping tradition was a part of the African culture, even prior to slavery, and this tradition was common across diverse African societies. Life was organized around the family and so deep was the feeling of helping and sharing that even those who did not participate in the 'exchange' could expect to receive help, especially in times of emergencies (Martin & Martin, 1985).

Kinship bonds were strong in traditional African families; smaller family units (nuclear families) were seen as part of a larger extended family network. These larger networks would then make up a clan, with several clans making up a tribe or community. Everyone was treated

like kin and the feelings of helping and sharing were deeply rooted in the African way of life. The traditional African kinship system was one that reached out, linking each person to everyone else. The extended family ties were the basis for caregiving and one received help even if they were not a relative by blood or marriage (Martin & Martin, 1985).

During slavery, the slave family included both kin and non-kin and everyone knew that at any moment a spouse, sister, brother, mother, or father could be sold and never be seen or heard of again, making family ties even more precious. While slavery destroyed the traditional Black family by uprooting its members, it did not destroy the strong feeling of family that slaves had deep within their souls and this tradition of fictive kinship continues in the African American culture today (Martin & Martin, 1985).

In traditional Africa, the old and the young were cared for by all members of the community. The elderly were held in high esteem because African people believed that living a long life meant being wise and knowledgeable. Death was described as passing from one realm of life to another or as a passage from the evils of this world to another state. The funeral was often (and still is) celebrated as a joyous occasion, with a party after the burial (Spector, 1996). During slavery, as in traditional Africa, the aged were looked up to and respected throughout the slave community and the strong sense of kinship made the life of older slaves easier to bear. The values of helping, caring, and respect for elders were taught to slave children. They witnessed slaves coming together to assist a new slave on the plantation, rallying to care for the aged and the infirmed, sharing their resources, and treating non-kin like blood relatives (Martin & Martin, 1985). This kind of family and community support and exchange continues among African Americans today.

3.1.3 Self-Care

In contrast to formal mechanisms of health care, 'self-care' refers to the informal and/or traditional actions by which individuals manage their own health. Becker, Gates, and Newsom (2004) examined the social, cultural, and historical roots of daily self-care practices of African Americans' and explored cultural factors in relation to the development of self-care processes and their use in daily life after diagnosis of a chronic illness. They found that while cultural factors were at the root of self-care practices, socioeconomic status and health insurance status shaped access to health care resources. Individuals who had some form of health insurance more frequently reported the influence of physicians and health education programs on self-care regimens than did those who were uninsured. Self-care practices also varied in relation to other health and social concerns such as access to health care, employment, access to medication, availability of information about illnesses, and ability to make ends meet in daily life. In the absence of regular health care, respondents relied even more heavily on self-care practices they had learned when younger. Becker et al. (2004) concluded that the cultural components of self-care have not been thoroughly investigated and that the lack of access to health care limits individuals from potentially maximizing chronic illness management through self-care strategies.

Not all of the respondents in the Becker et al. (2004) study indicated they used traditional medicine at the time they were interviewed. Three culturally-based themes of self-care approaches emerged from the study: (1) spirituality, (2) social support and advice, and (3) non-biomedical healing traditions. These cultural factors were consistent regardless of socioeconomic status and included a diverse range of activities.

3.2 RESEARCH ON HELP-SEEKING, SOCIAL SUPPORT, AND HEALTH CARE

There is still a void in the literature specifically about health behavior and the needs of older Black women as a specific sub-group. However, a good deal has been learned about Blacks, in general, through research conducted on help-seeking behavior and service utilization since the early 1980s.

Drawing from a longitudinal survey of 1,106 urban adults aged 20 to 70, Brown (1978) found that help seekers reported more emotional issues than non-seekers, and they turned primarily to their physicians for formal help. Research has suggested that patterns of help-seeking behavior were influenced by whom the person consulted when deciding whether or not to seek formal care (Brown, 1978; Neighbors, 1984). Further, Calnan (1983) reported that decisions regarding help-seeking patterns varied depending on the perceived seriousness of the condition, and those decisions were also influenced by the status of the person advising the sufferer. Branch and Jette (1983) reported extensive use of informal support among elders who were unable to perform instrumental/secondary tasks (i.e., housekeeping, cooking and transportation). Greater reliance on formal support providers was apparent among older persons who required assistance with more basic or primary tasks (i.e., dressing, walking, and bathing).

Neighbors (1984, p. 559) has suggested that understanding "self-defined labels" is important because they represent the primary problem definitions that influence whether or not professional help is sought. Neighbors and Jackson (1984) looked at patterns of illness behavior in the Black community across all age groups. Their findings indicated that, with the exception of physical health problems for which both genders and all age groups sought formal help, most people either relied solely on informal help or they used it in combination with professional help. They found that age, gender, and type of problem were all significant factors in help-seeking

behavior, with women generally more likely than men to seek both formal and informal help. Women and the elderly, in general, were also more likely to combine informal and formal help for the same type of problem. People, in general, experiencing emotional problems (i.e., depression) were unlikely to seek any type of help at all. Based on their findings, Neighbors and Jackson (1984) reported that a substantial proportion of older Blacks are unwilling or unable to find help when they need it. The investigators indicated that these findings illustrate the need to investigate barriers older Blacks potentially face in obtaining help (Neighbors & Jackson, 1984).

Other studies have addressed the relationship between social support, which can be conceptualized as a form of lay consultation, and health. The work of Chatters, Taylor and Jackson (1985) called attention to the role played by friends, neighbors, and other non-family associates as support providers. They found that the family was extensively involved in the informal support network, with gender, marital status, and region being significant predictors of network size. Elderly Blacks indicated that daughters were selected most frequently to help respondents who were sick or disabled; the married elderly and those with children had larger helper networks than other groups; and one of the most critical support relationships occurring between the elderly and their significant others centered around support during an illness. While older women in the Chatters et al. (1985) sample had larger helper networks than older men, both widowed and never married persons generally had significantly smaller networks. Also, compared to those respondents who resided in the South, respondents in the North Central and North East regions of the country all had significantly smaller helper networks.

Padgett (1989) suggested that the resilience of aging minority women allows them to draw on strengths -- psychological, social and cultural -- that ease the transition to old age, even in the midst of challenges. Since Black men tend to rely on their own individual coping

strategies and resources, they may not seek professional help as often as Black women, and this may place them at risk for increased morbidity (Neighbors & Howard, 1987). Million-Underwood and Sanders (1990) reported that this may be more of a cultural effect than a gender effect due to the history of perceived institutionalized racism often directed at Black men and their mistrust of the health system or their perception that health is an unrealistic luxury.

Hatch (1991) explained the higher involvement of friends, neighbors, and co-workers as being due to the meaning Blacks attached to non-relatives and the role they play in the support network. Ford (1992) examined the concepts of health-protecting behaviors, practices and attitudes that shape health care behaviors among 407 rural Black elderly women aged 68 to 90 and found that their health problems differed sharply from those of other racial groups because of older black women's physical environment, income, work, and health conditions. Although many of their behaviors did not involve contact with the formal health care system, Ford (1992) found that the women she interviewed actually performed a variety of behaviors to protect their health (e.g., eating nutritional meals, using home remedies, using over-the counter drugs). Ford (1992) suggested that some of the variance in behavioral responses to symptoms and illness knowledge about disease, perceived efficacy of health action, health education, symptoms of illness, accessibility, may be explained by group influence and the fact that their health beliefs were enmeshed in the socio-cultural fabric of the rural community (Ford, 1992). For example, the women considered it an indication of health to avoid use of the formal health care system, even though they might have needed formal services. Many of the women considered themselves healthy despite biological or physical problems as long as they could function socially and were fairly ambulatory. Neither education nor income emerged as statistically significant in the Ford (1992) study. Although there was no significant differences between

health-related activities and marital status, respondents who were married performed more health related activities than those who were single. Ford (1992) reported that an unexpected finding was that the oldest women (80-89) performed more health-related behaviors than the younger women (60-69).

The help-seeking behavior of elderly black women is best articulated by the women themselves. In a qualitative study exploring issues related to breast cancer in older African American women, Tessaro, Eng, and Smith (1993) found that: (a) other health concerns are of more important to the women than breast cancer; (b) age is generally not recognized as a risk factor for breast cancer; (c) fear of finding breast cancer and its social consequences are salient barriers to mammography; (d) there is a tendency to rely on breast self-exam rather than mammography to detect breast problems; (e) cost may be more of an issue of competing priorities than finances per se; (f) the tradition is to go to a doctor for a problem, not for prevention; and (g) women in their own social networks are important resources of social support for health concerns.

Blacks have persistently higher mortality and morbidity rates than do whites (Dressler, 1993; Wallace, 1990). As a result, much has been written about differences in health care use and access, as well as formal help utilization. Silverstein and Waite (1993) examined differences in the use of social support as reported in the National Survey of Families and Households. Their findings showed that Black women were less likely than White women to provide instrumental support to others. However, Blacks and Whites were similar in receiving instrumental support from others or providing or receiving emotional support to others. According to the authors, the findings suggest that claims in the literature asserting heightened

support activity among Blacks may be overstated, if not utterly false, when they are globally made (Silverstein & Waite, 1993).

Silverstein and Waite (1993) also proposed that race differences in propensity to provide and receive support were contingent on the age of the group being studied. Although they found that Black-White differences were generally consistent over the age range among men, the differences between Black and White women were reduced as age increased. White females were more likely than Black females to receive instrumental support in middle age, but by age 55 Black women received more instrumental support than White women and this difference continued to increase into old age. Similarly, White women gave more instrumental assistance than Black women earlier in life, but were more or less equivalent to Blacks by about age 70 (Silverstein & Waite, 1993). However, Silverstein and Waite (1993) only considered support activities with others outside of the household. They did not take into account the possibility that Black women provide a great deal of support to their household members.

Nelson (1993) looked at race, gender, and the effect of social supports on the use of health services. Nelson found that African American females living alone were significantly more likely to contact a physician for health problems than were White males or White females who lived alone. White males with siblings were statistically less likely than their African American counterparts to contact a physician; however both Black and White females were more likely to visit a physician if they had siblings (Nelson, 1993). Nelson found differences between African American males and females in the level of influence relatives had on their contacting a physician. African American males who got together with their relatives contacted a physician more, but when they got together with their friends, physician contact decreased. The opposite

was true for African American females. Their physician contact decreased when communicating with their relatives and it increased when they got together with their friends (Nelson, 1993).

Much of the literature provides evidence that strong and supportive social relationships are associated with the health of individuals who live within such social contexts (Berkman, 1995) and social support is important to health and to compliance related to health behavior (Antonnuci, Ajrouch & Janevic, 1999). A recent study by Bentera (2003) looked at psychosocial factors and ethnic disparities in the diagnosis and treatment of diabetes. Social support was defined as informal social participation that occurs as part of a natural social interaction and included a network of individuals represented by contacts with friends, family, and neighbors as well as by interactions at church or in a social group. The study found that a significant number of undiagnosed older adults showed signs of diabetes and that among the older adults who were unaware they had diabetes, the African American respondents reported frequent visits and phone contacts with family and friends as well as ongoing attendance at club meetings and church services (Bertera, 2003). Bertera suggested that simply treating acute conditions may represent a missed opportunity for health care providers and social workers. The author proposed that social workers could effect change in this situation by addressing risks such as obesity, unawareness of glucose levels, and patterns of social support and affiliation during the social work assessment. This would allow social workers to assess the total needs of the person and then help him or her develop coping mechanisms (Bertera, 2003).

3.3 SUMMARY

In this chapter, I draw upon our knowledge of the "Black Helping Experience" that is rooted in both history and tradition, and I discuss how these can inform the health behavior (health beliefs, health practices, and health-seeking) of many African Americans, and, more specific to this study, of older African American women. This historical context adds another dimension to the Chrisman concepts and supports a deeper understanding of how the health seeking process is influenced, both socially and culturally.

4.0 METHODOLOGY

This chapter describes the methods used to examine the health-seeking behavior of a sample of older Black women. The chapter begins with a discussion of the original study from which the data used in this study were drawn. Following this, I describe the key concepts and variables used to address the research questions as well as the method for content analysis employed.

The data used in this dissertation were based on responses from a sample of older African American women interviewed for the National Institute of Aging (NIA) study, *Health Behavior of Older Blacks*, which was funded in 1992 as a supplement to a larger NIA study, *Geriatric Health Care and Assessment: A Controlled Randomized Prospective Study.* Dr. Myrna Silverman (Professor, Graduate School of Public Health) was the Principal Investigator.

4.1 THE PARENT STUDY: THE GERIATRIC ASSESSMENT UNIT (GAU) STUDY

This parent study, referred to as the Geriatric Assessment Unit (GAU) study, was conducted between 1990 and 1991. It involved recruitment of non-institutionalized older adults to evaluate the process and outcomes of outpatient geriatric assessment compared with traditional community care. To be eligible for the study, individuals had to meet the following criteria:

- Race (Black or White only)
- Had Medicare Part B or Medicaid

- Were experiencing instability or a change in their health status during the previous 6 months

Exclusion criteria included nursing home residents, those unwilling to be randomized, those already in a geriatric program or other study, those with a terminal illness or schizophrenia, and those considered to be too healthy. Participants and their families were recruited throughout the community at large using various strategies designed to reach the older population or their caregivers. A total of 1,265 people expressed interest in the study and were screened by telephone to determine their eligibility. The final GAU sample population consisted of 442 persons 65 years of age or older, who had Medicare Part B and Medicaid and who had experienced some acute illness or change in health status in the past six months. Of the total 442 participants in the GAU study, 358 (81%) were females; 138 (31%) of those 442 participants were African American.

With the exception of the initial phone screening interview, all interviews took place in the participants' homes to allow for a more natural process in a familiar setting. Participants were interviewed four times in their homes or in some mutually identified location and completed short monthly phone interviews to obtain information related to health services utilization (Silverman, Musa, Martin, Lave, Adams, & Ricci, 1995). Informed consent was obtained at the initial in-person interview. The baseline and subsequent interviews gathered information on socio-demographics, perceived health status and social supports. Current living arrangements, frequency of social contacts with family, friends and professionals, and self-rated adequacy of social support were also addressed.

Parent study interviews at 4 and 8 months provided short term outcome data, tracked the study data, and collected the same data as the baseline interview, with the exception of dementia

and depression measures. The 12 month interview provided long term outcome data and repeated all baseline data measures. Caregivers were also interviewed by telephone every 4 months to obtain their sociodemographic information, types of caregiving activity they were engaged in, and the type of help received from others.

4.2 THE SUPPLEMENTAL STUDY: HEALTH BEHAVIORS OF OLDER BLACKS

In 1992, the *Health Behaviors of Older Blacks,* a supplement to the original GAU grant, was funded by NIA to identify factors contributing to health status differences and health related behaviors of the group of elderly Blacks participating in the original NIA study. The supplemental study had three aims (Silverman et al., 1995):

1. To gain a better understanding of the health related characteristics of a group of heterogeneous Blacks
2. To perform two types of supporting analyses on data collected for the larger evaluation study, comparing effects of geriatric assessment by race
3. To compare general health status and other health related characteristics by race, attempting to explain differences.

Seventy-three of the African American respondents (67 females [92%] and 6 males [8%]) involved in the GAU study agreed to participate and be interviewed again specifically for the supplemental study. Complete interview transcripts were available for 45 women. There were too few men to use as a comparison group. Therefore, those 45 women formed the sample examined in this dissertation.

4.2.1 The Interview Instrument and the Interviews

In the supplemental study, the intake interview served as a screening tool, gathering data on the recruitment source, self-perceived problems, symptoms and health care history. The interview was conducted by telephone with the potential participant or caregiver. A pre-coded semi-structured questionnaire (Appendix A) was developed by the research team for the in-person supplemental interview. This questionnaire was divided into three primary sections: Health Status and Demographics, Health Care Practices, Health Knowledge and Beliefs. The instrument was piloted tested and based on those results revisions to the instrument were made. Participants in the supplemental study were interviewed using this new instrument. These data were used for the dissertation.

Open-ended and closed-ended questions and prompts served to enrich each woman's narrative and allowed the woman to respond in her own words. According to Tutty, Rothery, and Grinnell (1996), this approach is less restrictive, allowing each woman to answer in a way that reflects her experience and opens up the number and type of potential responses.

The Research Assistant conducting the interviews was an African American female, trained as a social worker and licensed by the Commonwealth of Pennsylvania. She had previous experience conducting open-ended interviews. She audio-taped each interview, took handwritten notes, and noted her own observations about the interview and the interviewee. Each interview lasted an average of 1½ hours. Each participant received $25 after the in-home interview.

4.3 THE DISSERTATION: EXPLORING HEALTH BEHAVIOR IN OLDER BLACK WOMEN

This study involved secondary analysis of data generated by the GAU supplemental study. Specifically, I focused on analyzing the responses of the women who participated in the supplemental study. I employed quantitative analysis of several survey questions and qualitative content analysis of several broad, open-ended questions. The analysis was exploratory and descriptive looking at this group of women at one point in time and making no comparison to other groups nor explaining cause and effect. In-depth description gives us a reasonably accurate picture of the way things were at the time the research took place, beginning the process of knowledge-building and laying the groundwork for other knowledge-building to follow (Yegidis et al., 1999).

The key concepts of the Chrisman model were used to organize the participant responses to the supplemental survey questions. I completed this data analysis to answer two specific research questions related to the health behavior of the 45 women interviewed:

1. What are the health-related behaviors of older African American women?
2. Are age, education, living arrangement, and marital status related to their perceived health status?

4.3.1 Key Concepts

Key concepts examined in the current study were derived from the five components of the Chrisman (1977) model for health-seeking behavior. These concepts provided the organizing framework for the exploration of health behavior themes: symptom definition, illness-related

shifts in role behavior, lay consultation and referral, treatment actions and adherence. Table 1 identifies the Chrisman concepts, their definitions, and the corresponding supplemental study question that provided the data used in this analysis.

Table 1: Chrisman Health-Seeking and Relevant Survey Questions

Conceptual Definition	Operational Definition	Relevant Survey Question
Symptom Definition	Culturally based explanation or category giving meaning to the experience	How did you first decide you had a problem? Please tell me whether that problem would cause you to seek help? ▪ A persistent stomach problem ▪ Persistent headaches ▪ Persistent pain ▪ Not being able to get around as much as you used to ▪ Forgetting more often than you used to ▪ Feeling sad a lot of the time ▪ Just not feeling good all over ▪ A fever How much do you agree with the following statements? ▪ Many health problems that older people have are caused by old age and can't be helped. ▪ People who take care of themselves stay healthy. ▪ I don't believe doctors can do everything they say they can do. ▪ A person understands his/her own health better than most doctors ▪ Some home remedies are still better than the medicines the doctor gives you for curing sickness.

Table 1 (continued)

Conceptual Definition	Operational Definition	Relevant Survey Question
		▪ I have no reason to worry about diseases because I can always go to my doctor and get cured. ▪ Sometimes when you're sick, someone you know can help you get well better than a doctor can. ▪ God will take care of me so I don't worry too much about my health. ▪ Sooner or later, medicine is going to solve everybody's health problems. ▪ There are a lot of things you can do to stay healthy and avoid illness.
Illness-related Shifts in Role Behavior	Relaxation or cessation of person's obligations based on illness-related restrictions	How much does your health troubles stand in the way of your doing the things you want or need to do?
Lay Consultation and Referral	Calling on others for aid in identifying an illness, for suggestions about treatment, and for recommendations of competent professional help	Did you ask anyone's advice about what to do or where are to go?
Treatment Action(s)	Behaviors in which the individual engages in attempting to cure or reduce the impact of the health problem	**Informal:** Did you do anything yourself to make you feel better either before, during or after seeking help? Are there some health problems that you treat yourself (e.g. colds, allergies, back pain, etc.)? Did your family ever use any home remedies to cure illnesses while you were growing up? Do you still use home remedies? **Formal:** Have any of your (regular doctors) been black? Would you rather go to someone who is black? Have any of your (regular doctors) been women? Would you rather go to someone who is a woman?

Table 1 (continued)

Conceptual Definition	Operational Definition	Relevant Survey Question
Adherence	The degree to which the person acts upon treatment advice	Did you follow the advice you received? Did you feel that (doctor) was concerned & willing to listen to you? Did you have confidence in (doctor) (Did you think (Dr. ___) was a good (doctor, chiropractor, etc.) Did (doctor) or staff (if applicable) make you feel uncomfortable in seeking help? If so, in what way?

Selected demographic characteristics were also examined for emerging themes. These demographics included: age, educational attainment, self-reported health status, income, living arrangement, and marital status (Table 2).

Table 2: Demographic Characteristics

Characteristic	Categorized/coded as:
Age (groupings based on national data sets)	65-74 years 75-84 years 85 years and older
Educational Attainment (no. of years completed)	0-6 grades 7-12 grades 13 grades and above
Income (on further analysis these variables were collapsed as <$5,000 and ≥$5,000).	Under $5,000 $5,000-$10,000 $20,000-$30,000
Living Arrangement (on further analysis, 'with daughter/son' was collapsed with 'others').	Alone With Spouse With Daughter/Son (No spouse present) With Others
Marital Status (on further analysis reverse coded and collapsed 'separated' with 'divorced').	Married Widowed Separated Divorced Never Married
Self-reported Health Status (on further analysis, reversed coded -- 'poor' and 'good' were collapsed as were 'good' and 'excellent').	Poor Fair Good Excellent

4.3.2 Content Analysis

Secondary analysis is the process of using data that have been collected for some other purpose to provide answers to another investigator's research question (Miles & Huberman, 1984). This type of analysis can be used to conduct an exploratory study, a descriptive study, or even an

explanatory study. In this particular case, these data, collected for the supplemental study, were never before analyzed. Therefore, this exploratory analysis reveals the first findings from the NIA supplemental study.

In this study, the qualitative data available included field notes of observations and interactions with participants, taped recordings of the interviews, and typed transcripts. As is common in qualitative research, data reduction in this study involved a series of steps and data analysis was an ongoing process of comparison and categorization. The following points illustrate the steps undertaken:

- Raw data from the supplemental study were extracted from the parent GAU study data.
- Raw data were extracted from the supplemental study data set.
- After a thorough review of the raw data, all incomplete interviews were excluded.
- The demographic characteristics were organized for each participant, based on information received during the supplemental interview.
- Demographic characteristics were then categorized and coded, as previously described in Table 2.
- All 45 completed transcripts of those included in this study's sample were read and reviewed for content.
- All interviewer field notes associated with these respondents were reviewed.
- The Supplemental interview instrument was reviewed for selection of specific questions to include in the analysis.
- Selected questions were appropriately reviewed for matching with key concepts of the Chrisman model.

- A code book for selected open-ended responses was created, matching the responses appropriately to the Chrisman key concepts.
- A table was created to display the demographics of each respondent and her responses corresponding to Chrisman concepts.

When I was beginning to analyze these data, I was being trained to use NUDIST, a qualitative software package. However, given the complexity of NUDIST at that time and the small sample size I was working with, I decided to analyze the qualitative themes by using an approach many investigators have used prior to the creation of qualitative software. In essence, I created a table that ultimately provided a visual display of the data. The first row of the table included headings for each column: ID number and demographic characteristics, and the five Chrisman concepts (symptom definition, illness-related shifts in role behavior, lay consultation and referral, treatment actions, and adherence). As I read through the electronic version of the transcribed interviews, I cut and pasted the responses to the selected questions (Table 2) under each of the headings.

4.3.3 Quantitative Data Analysis

Responses to the close-ended questions were coded and entered into SPSS. The initial analysis involved the examination of variable frequencies to identify outliers and to check for data entry errors. Descriptive analyses were undertaken to characterize the women who participated in the current study in terms of their health status, age, education, income, living arrangement, and marital status.

All continuous variables were summarized by means and standard deviations, and comparisons were made using Student t-tests for normal continuous variables and the Wilcoxon test for non-normally distributed variables. Categorical variables were summarized by frequencies, and statistical significance was assessed with chi-square tests. Fisher's exact test was used when expected cell sizes in 2x2 tables were less than five. The criterion for determining statistical significance was set at $p \leq 0.05$ (two tailed).

To examine the impact of the five demographic variables on self-rated health status while controlling for the influence of other potentially confounding variables, a logistic regression model was developed using self-rated health status (poor/fair vs. good/excellent) as the dependent variable. The goal of the logistic regression analysis was to determine whether these variables predicted health status.

4.4 RELIABILITY AND VALIDITY

The validity and reliability of qualitative data depend to a great extent on the methodological skill, sensitivity, and integrity of the researcher(s) (Patton, 1992). Based on my understanding from the Principal Investigator of the parent and supplemental studies, strong consideration to the issues of validity and reliability was given throughout the research period. For example, ongoing communication and meetings with project leaders and the entire research team – including the interviewer and project coordinator -- occurred throughout the study. These meetings were to ensure the integrity, credibility, confidentiality, and consistency of the research data and data collection process. These team meetings also included discussions and decisions related to the research design, data collection methods, and the use of the interview instrument.

Additionally, one out of every five interview transcripts was subject to a reliability check. Throughout the study, the Project Coordinator checked the taped interviews for consistency in questioning and to insure that the interviews were not conducted in a biased or directive manner. After each interview, field notes were typed and tape recordings were transcribed for all respondents completing the interviews. Within a few days of each field contact, the interviewer met with the research team to talk about the completed interview and document any significant observations related to the interview or the interviewee. This process aided the team in making revisions to the upcoming interviews, including areas that the next interview should perhaps focus on, emphasize, probe, or clarify.

4.5 HUMAN SUBJECT CONCERNS

In the parent study, a total of 1,265 people expressed interest, and 442 became eligible participants. Those individuals were screened by telephone and if they qualified they were interviewed in person. During the in-person interview, an informed consent statement was read to and reviewed with the potential participant. The consent form was approved by the University's Institutional Review Board (IRB #991045). It included information on the research procedure, the study purposes, risks and anticipated benefits, and a statement offering the subject the opportunity to ask questions and to withdraw at any time from the study. This initial interview provided the baseline information on each study participant.

All African Americans participating in the parent study were invited to be interviewed once more for the supplemental study. The same informed consent process was followed to protect human subjects and maintain the ethical principles and integrity of the study. Since the

current study analysis involved secondary data, and I was unable to link responses to specific individuals, human subjects' protections were provided by the original studies.

4.6 SUMMARY

In summary, data for this dissertation were drawn from a sample of 45 African American women, 65 and older, who participated in a larger study examining health behavior in older Blacks. Descriptive analyses was based on several demographic characteristics of the women, including age, education, income, living arrangements, and marital status. These characteristics were examined in relation to self-perceptions of health and as potential predictors of those perceptions. Qualitative responses were related to specific variables such as health beliefs, practices, and preferences; they were organized around key concepts related to a health-seeking process, as described by Noel Chrisman (1977).

5.0 STUDY RESULTS

The main objective of this dissertation was to describe themes related to the health behaviors of 45 elderly African American female respondents who participated in the *Health Behavior of Older Blacks* study, a supplement to the National Institute on Aging (NIA) funded *Geriatric Health Care and Assessment* study (RO1 AG08276).

The results detailed in this chapter address two basic research questions about these women:

1. What are the health-related behaviors of older African American women?
2. Are age, education, living arrangement, and marital status related to their perceived health status?

This chapter is divided into three main sections. The first section summarizes selected demographic characteristics of the study population. This is followed by a discussion of participants' self-rated health status, including a description of the relationship between their self-rated health status and selected demographic characteristics as well as the results of a logistic regression analysis performed to determine if these demographic characteristics predicted self-rated health status. The third section presents an analysis of responses to a series of questions about help and health seeking and health care. The analysis was guided by the five

key concepts of the Chrisman (1977) model for health-seeking behavior: symptoms, illness shifts in role behavior, lay consultation and referral, treatment actions, and adherence.

5.1 THE DEMOGRAPHIC CHARACTERISTICS OF THE STUDY POPULATION

As Table 3 shows, 40% of the study respondents were 65-74 years of age, 44% were 75-84, and 16% were 85 and over. The average age of the women was 77 (SD = 6.9). Only one woman had no formal education. The majority (69%) completed the 7^{th} to 12^{th} grades; four had some post-high school education, with one of them reporting as much as two years.

Almost half (42%) of the women had an income of less than $5,000 and over half of them (57%) reported incomes between $5,000 and $10,000. There were no reports of income between $10,000 and $20,000. However, one woman did report income over $20,000.

At the time of the interview study, the majority (64%) of the women lived alone; almost 16% of them reported living with someone other than their spouse. Sixty-four percent (64%) reported being widowed. Only 13.3% of the women were married at the time of the interview. Approximately 18% had never been married.

Table 3: Demographic Characteristics of the Study Population

Variable	Frequency	Percent
Age		
65-74	18	40.0
75-84	20	44.4
≥ 85	7	15.6
Mean	**77**	
Education		
0-6	9	20.5
7-12	31	70.5
≥ 13	4	9.1
Missing	**1**	
Income		
< 5,000	19	43.2
≥ 5,000	25	56.8
Missing	**1**	**2.2**
Living Arrangement		
Alone	29	64.4
With Spouse	9	20.0
With Others	7	15.6
Marital Status		
Married	6	13.3
Widowed	29	64.4
Divorced	8	17.8
Never Married	2	4.4

5.2 SELF-RATED HEALTH STATUS

Asking people to assess their own health is a common way to determine health status. Self-assessed health status correlates with mortality and morbidity risk (Musa et al., 2004). When the women were asked how they rated their own health compared to others their age, responses were pretty evenly distributed between poor/fair and good/excellent (Table 4).

Table 4: Self-Rated Health Status

Rating	Frequency	Percent
Poor/Fair Health	23	51.1
Good/Excellent Health	22	48.9

5.2.1 Demographic Characteristics and Self-Rated Health Status

I examined relationships between self-rated health status and age, education, income, living arrangements, and marital status (Table 5). With the exception of income, none of these relationships achieved statistical significance. Women who had an income greater than $5,000 were more likely to report their health status as good or excellent in contrast to women with lower income. Although not statistically significant, the youngest age group in this study's sample characterized their health more negatively than did the older respondents. This may be due to chance or it may be a reflection of the original study's selection criterion (i.e., a change in health in the six months prior to selection). Other measures (e.g. role behavior, self-care) were also examined in relation to self-rated health status and those results are reported later in this chapter.

Table 5: Selected Characteristics By Self-Rated Health Status

Characteristic	**Poor/Fair N (%)**	**Good/Excellent N (%)**	**Chi-Square**
Age Group			1.81
65-74	11 (61.1)	7 (38.9)	
75-84	8 (40.0)	12 (60.0)	
≥ 85	3 (42.9)	4 (57.1)	
Educational Level (Grades)			1.06
0- 6	4 (44.4)	5 (55.6)	
7-12	16 (51.6)	15 (48.4)	
≥ 13	1 (25.0)	3 (75.0)	
Income			6.42*
< 5 K	14 (70.0)	6 (30.0)	
≥ 5 K	8 (32.0)	17 (68.0)	
Living Arrangement			1.69
Alone	13 (44.8)	16 (55.2)	
With Spouse	4 (44.4)	5 (55.6)	
With Others	5 (71.4)	2 (28.6)	
Marital Status			2.96
Married	1 (16.7)	5 (83.3)	
Widowed	16 (55.2)	13 (44.8)	
Separated/Divorced	4(50.0)	4 (50.0)	
Never Married	1 (50.0)	1 (50.0)	

p < .05

5.2.2 Predicting Self-Rated Health Status

Table 6 presents the results of the logistic regression analysis in which the five selected demographic characteristics were regressed on the dichotomous self-rated health status variable. As the table displays, income was the only demographic characteristic to predict self-rated health status among these 45 women. Thus, women with an annual income of greater than $5,000 per year were almost seven times (6.9) more likely to characterize their health as good/excellent compared to women with an income less than $5,000 per year.

Table 6: Logistic Regression Predicting Perceived Health Status

Predictor	B	S.E. N (%)	Wald $\chi 2$	OR (95% CI)
Age Group	0.75	0.50	2.25	2.1 (0.8-5.7)
Educational Level	0.26	0.64	0.17	1.3 (0.4-4.6)
Income	1.94	0.77	6.39*	6.9 (1.5-31.2)
Living Arrangement	-0.58	0.49	1.36	0.6 (0.2-1.5)
Marital Status	-1.80	0.53	0.01	0.9 (0.3-2.7)

-2 Log likelihood = 49.669; * $p < 0.05$

5.3 HEALTH-SEEKING BEHAVIOR: THE CHRISMAN MODEL

In this section, the five key concepts of the Chrisman model of health-seeking behavior are used to organize the responses study participants gave to a series of closed-ended and open-ended follow-up questions.

5.3.1 Symptom Definition

According to the Chrisman model, symptom definition begins with a perception of a "deviation from the culturally and historically variable standard of normality established by everyday experience" (Friedson, 1970, p. 285). Most of the women in the study reported having bodily pain and/or emotional problems within the four weeks prior to the interview (Table 7).

Table 7: Distribution of Symptoms

Symptom	Frequency	Percent
Bodily Pain in Last 4 Weeks		
None	9	20.0
Mild	12	26.7
Moderate	9	20.0
Severe	15	33.3
Emotional Problems		
Not at All	14	31.1
Slightly	12	26.7
Moderately	7	15.6
Quite a Bit	12	26.7

To better understand how they recognized a health problem, participants were asked: "How did you first decide you had a problem?" Some respondents described problems that came to their attention through symptoms such as breathing problems, persistent pain, or female-related problems. Other respondents simply talked about a specific condition itself or an acute or chronic episode alerting them to seek help or medical attention. For example:

> I went to a gyne doctor because I had a boil, it erupted, and the boil was on the, on my vagina and so blood and pus came out. I didn't know where it was coming from so I thought I had cancer somewhere. It was on the tip of my vagina on the inside, um, this boil had formed. I never got any pain or anything from it. I never knew it was there, and I went to the bathroom and, you know, when you wipe yourself I saw blood and pus and I thought, oh boy, it upset me terrible. And I went to the doctor. (Ms. A, Age 71)

> I fell in the street (couldn't see median) and hurt my thumb – Got up and twisted it back into place – went home and soaked it in Epsom salt. Two days later, I was in excrutiating pain – went to ER and learned it was broken. My neighbors had advised me to go the same day but I didn't think it was anything serious. (Age 75)

Some women described symptoms that eventually were tied to the diagnosis of a chronic condition. One of them was eventually diagnosed with lung cancer:

> I couldn't walk very far without getting out of breath. I'd walk about a half a block and I'd have to stop and get my breath. I went over here to the clinic and they sent me straight to the hospital that same day. And then I was in the hospital for fifteen days. They started giving me chemotherapy while I was in there. I went back for six months taking chemotherapy. (Age 70)

> I kept being dizzy and I couldn't figure out what it was. So (while visiting a friend) I said, well, I'm going to the ladies room before I leave and I went in the bathroom and I sit down. I was beginning to feel kind of sick to start with. And after I had urinated I got up and I washed my hands and I got real faint, see, and the bathroom is a few steps from the toilet. It's not in the same room. So when I came back through the hall to go into the bathroom, like the bathtub is sitting right here and I passed it and fell over into it. (Age 84)

> This hard pain would come sort of like shooting right through my head and look like it would....right up top of my head. And it was so severe, when that hard pain would come and shoot to my head I would have to scream. I mean, I would scream. And that's when I had to make it to the doctor. I was screaming in the office so the doctors came running. And he gave me some kind of a pill and that stopped that shooting pain. But my neck was still sore, and I went, they sent me over to the clinic. Doctor gave me a shot. (Age 84)

Respondents typically defined symptoms based on their own personal experience and perception of something being different from their norm. However, the existence of symptoms did not necessarily lead to help seeking**.** Some women described a delay in seeking care for symptoms that existed for some time. They appeared to be making a decision based on personal assessment criteria that the problem did not really necessitate formal care. It is unclear how the situation would have had to be different for them to seek that help sooner.

> I don't just go when it first happens. Sometime I might let it run maybe a month or maybe longer before I go. (Age 76)

> Oh, well, I, uh, sometime I have terrific stomach pains at times. But then just like it come that's the way it leaves. Well, it just bothered me a lot, just hurt in the lower part. It's in the lower part of my stomach. But that's nothing, I've had it now for, oh, I guess five or six years. But it's something that seems to go and come. (Age 82)

> I was thinking about going to one (doctor). I have like a cyst on the left lip of my uterus, and it was just about like this maybe a year ago in size. And now it's about the size of a jelly bean egg, you know. (Age 86)

Respondents were given a list of health conditions and were asked: "Please tell me whether this problem would cause you to seek help?" Responses indicate that almost all of the women would seek help for severe stomach problems (98%) or pain (93%); the majority also would seek help if they were unable to get around (67%), were forgetting things often (71%), or were having a fever (71%). Less than half of the women interviewed considered being sad as a reason for seeking help (Table 8).

Table 8: Symptoms Leading to Help Seeking

Symptom	Yes	Percent
Persistent Stomach Problems	44	97.8
Pain	42	93.3
Headaches	35	77.8
Forgetting Often	32	71.1
Fever	32	71.1
Unable to Get Around	30	66.7
Not Feeling Good All Over	25	55.6
Sadness	20	44.4

This result is not surprising as African American women tend to use self-reliance and traditional coping strategies (prayer, worship, praise) in response to depression (Musgrave et al, 2002). For example:

> Wouldn't go to doctor or hospital for feeling sad a lot, because I never considered doctors to have anything to do with that. Sometime you just get in a mood, a state. (Age 84)
>
> Just to feel sad. I wouldn't go to no doctor for that because I'd feel like I was doing it on my own. I try not to, you know, let things bother me that much. (Age 84)

5.3.2 Illness-related Shifts in Role Behavior

Chrisman suggested that one way of conceptualizing the introduction of other persons (e.g. lay consultation and referral) into the health-seeking process is to focus upon the second aspect of health seeking: illness-related shifts in role behavior. In other words, others are either informed

of the problem or notice it themselves when the individual with the problem has to make modifications in her normal role behavior.

To explore the concept of illness-related shifts in role behavior, I analyzed the women's responses to several close-ended questions about how their health troubles stood in the way of their carrying out roles and responsibilities and participating in routine and social activities. As illustrated in Table 9, most of the respondents (76%) indicated that their health troubles did stand in the way of their normal roles and their routine activities, at least a little. About 70% reported that their health, at least to some degree, made it difficult for them to do their daily chores, with almost 16% indicating they could not do such work at all. Of the 33 women whose health troubles interfered with their doing things, 73% attributed the cause of their difficulty to mostly physical limitations, while the remaining 27% attributed the difficulty to both physical and emotional causes.

Table 9: Illness-Related Shifts in Role Behavior

Variable	Frequency	Percent
Health Problems Stand in Way		
Not at All	11	24.4
A Little	19	42.2
A Great Deal	15	33.3
Difficulty Doing Daily Chores		
None at All	13	28.9
A Little Bit	6	13.3
Some	11	24.4
Quite a Bit	8	17.8
Could Not Do Daily work	7	15.6
Cause of Difficulty Doing Chores		
Mostly Physical	24	53.3
Physical/Emotional	9	20.0

The higher the income, the less often women reported that their problems interfered with social activities and routine chore (Table 10). Women with higher income may well have had access to additional resources that could be used to overcome some of the barriers that might otherwise have kept them from doing what they wanted to do.

Table 10: Illness-Related Shifts and Income

	<5,000 N (%)	**≥5,000 N (%)**
Not at All	1 (4.3)	9 (5.7)
A Little	10 (8.2)	9 (10.8)
A Great Deal	8 (6.5)	7 (8.5)

There was a statistically significant association between self-rated health status and health troubles standing in the way of doing things, difficulty with chores, and the cause of difficulty with chores (Table 11). Generally, women who indicated that health problems stood in the way or who reported difficulty with completing chores self-rated their health as poor/fair. Having health problems that interfere with chores and social activities appears to negatively influence the self-rating of one's health status.

Table 11: Illness-Shifts in Role Behavior by Self-Rated Health Status

	Poor/Fair N (%)	**Good/Excellent N (%)**	**Chi-Square**
Health Problems Standing in Way			10.67*
Not At All	1 (9.1)	10 (90.9)	
A Little	10 (52.6)	9 (47.4)	
A Great Deal	11 (73.3)	4 (26.7)	
Difficulty with Chores			10.08*
None At All	3 (23.1)	10 (76.9)	
A Little Bit	2 (33.3)	4 (66.7)	
Some	5 (45.5)	6 (54.6)	
Quite A Bit	6 (75.0)	2 (25.0)	
Could Not Do Daily Work	6 (85.7)	1 (14.3)	
Cause			8.26*
Mostly/Entirely Physical	13 (54.2)	11 (45.8)	
Physical/Emotional	7 (77.8)	2 (22.2)	

p≤.05

Four of the women added comments to illustrate how health problems interfered with activities such as walking, going to church, or participating in a social activity. For example:

> I just knew that wasn't normal 'cause I usually do much more walking than that every day. I could always walk farther than that. Still I can't go up the steps. I have to do one step at a time. (Age 70)
>
> I'd be in a car and have to get out and stand awhile because of the pain. (Age 86)
>
> I have quite a bit of difficulty doing chores. (Age 81)
>
> I can't go to church anymore. (Age 74)

Interestingly, one woman who stated that her health problems interfered a great deal also considered her health status to be "good." This respondent had night blindness, but she reported no bodily pain or emotional problems; she also indicated that her physical health had not interfered at all with her normal social activities with family, friends, neighbors, or groups. Most important to her, she was still able to attend church. Not knowing how long she had this impairment, I wonder if she had adjusted her activities and life to the night blindness some time ago or whether most of her activities occur during the day, when her sight is less of an issue.

5.3.3 Lay Consultation and Referral

Chrisman (1977) referred to lay consultation and referral as calling on others for aid in identifying an illness, for suggestions about treatment, and for recommendations of competent professional help. These activities imply the existence of shared health beliefs

and practices, and the presence of individuals available to influence the sick person's decision about what to do (Chrisman, 1977).

Respondents were asked where they got their health information and advice, and they were given a list of sources to respond to (Table 12). All but two respondents (96%) reported that their doctor/health provider was a source of health information. In fact, health personnel were the most common source of information (67%); no one listed the church as their most common source. Other sources of health information and advice included: reading (80%), television (73%), senior centers (67%), and friends (58 %). Less common sources were relatives, mail, the church and radio.

Table 12: Sources Used for Health Information

Sources	Frequency	Percent
Sources of Information		
Health Care Personnel	30	95.6
Reading	36	80.0
Senior Center	30	66.7
Friend	26	57.8
Relatives	21	46.7
Mail	19	42.2
Church	17	37.8
Radio	17	37.8
Sources Used Most Often		
Health Care Personnel	30	66.7
Reading	4	8.9
Radio	3	6.7
Senior Center	2	4.4
Relatives	2	4.4
Friends	1	2.2
Mail	1	2.2

There is a significant association between health and obtaining health information from a relative. However, this relationship was an inverse one. The healthier the participants perceived themselves, the less they tended to obtain health information from a relative (Table 13).

Table 13: Self-rated Health Status by Source of Health Information (Relative)

	No N (%)	**Yes N (%)**	**Chi-Square**
Health			4.98*
Poor/Fair	8 (36.4)	14 (63.6)	
Good/Excellent	16 (69.6)	7 (30.4)	

p=≤.05

The women were asked, "Did you ask anyone's advice about what to do or where to go?" In a follow-up to this closed-ended question, the women provided details regarding their beliefs

about whether or not to seek advice, from whom they sought advice, and the type of advice sought. Confidence in their doctors led to some women feeling that they need not consult with others. For example:

> See, I don't believe in asking everybody questions because I got one person that I have confidence in, and that's the only person I talk to is my doctor. (Age 80)
>
> No, I didn't really ask nobody for any help. I would often tell people my problems, you know, but.....I figure when you want help, you're sick and you want help, you go to the doctor. (Age 70)
>
> No, I never ask nobody but the Lord -- and the doctor if it gets a little bad. I just go get me some medicine, that's all. (Headache) I'll ask anybody. I go to the drugstore a lot of times and ask them.....If they get bad then I still have to go to the doctor, he will give me medicine, if they get too bad. (Age 84)
>
> I usually ask my doctor. (Age 70)

One respondent spoke of the power of social networks in influencing physician choice and referral patterns:

> I'd never discuss doctors with anybody but my very best friend I felt that if he was a doctor that was for her and she thinks a lot of him as a physician and would want to give me his name, I would take it, in all honesty. That's the confidence I have in this woman as a friend. (Age 86)

There were conflicting opinions about the appropriateness of seeking the advice of friends and family members. Some respondents felt that family and friends were not an appropriate source of advice. For example, women described their beliefs about seeking advice in the following ways:

> I don't pay that no mind (information from families and friends), because if you talk to two they both got different ideas, you know. Both got different ideas, so if you do everything your friends tell you you're doing something different every time you talk to one of them. (Age 71)

> I didn't think there was nothing they (people) could do. What did they know? It's my problem, I'm the one that's sick, have to go to the doctor when you get sick. (Age 70)
>
> You know, everybody can offer you their advice but none of them has licenses to practice medicine [laughs], you know. (Age 77)
>
> No, I never ask nobody but the Lord and the doctor. If it gets a little bad, I go get me some medicine, that's all. (Age 84)

Others did, in fact, routinely seek advice from family members and friends. Interestingly, family and friends generally suggested the respondents seek help from professionals. For example:

> I always ask my daughter and husband – they usually suggest I call the doctor. My husband always says call the doctor. (Age 81)
>
> One woman explained that neighbors advised her to go to the doctor the same day she fell, but she didn't think it was anything serious. Two days later, she was in excrutiating pain – went to ER and learned her wrist was broken. (Age 75)
>
> I told friends after I called the doctor – they said 'little too old to be seeing blood, you better go to the doctor . . . that's not a good sign'. (Age 71)
>
> I asked my daughter what she thought I could do about my sight. My daughter took me to see the doctor. (Age 92)

For some, the term "advice" was very loaded. Although several of the women indicated that they did not seek anyone's advice, they added these comments:

> I just talked to my girlfriend. (Age 76)
>
> I just mentioned it to my husband (or daughter). (Age 81)
>
> Oh, we always talk about our health, sure. That's all we have much now to talk about, we don't have no boyfriends so we talk about our illnesses. (Age 84)

5.3.4 Treatment Actions

Chrisman (1977) characterized treatment actions as behaviors in which the individual engages in her attempts to cure or reduce the impact of the health problem. Decisions about what to do when ill tend to be based upon knowledge and beliefs about bodily physiology, the nature of the environment, the etiology of disease, and available treatments (Chrisman, 1977).

The recognition of symptoms depends on how people define their normal health and what they understand to be the cause of the problem within a cultural context (Chrisman, 1977). We define our own health or illness, and determine what these states mean to us in our daily lives. We learn from our own cultural and ethnic backgrounds how to be healthy, how to recognize illness, and how to be ill (Spector, 1996). In this way, health beliefs can play a significant role in shaping help-seeking behaviors and treatment actions. This perspective is consistent with that of the Health Belief Model (HBM), which provides the theoretical framework for predicting the likelihood for care-seeking (Becker, 1974; Rosenstock, 1966).

Respondents were given a list of statements and were asked to indicate the degree of their disagreement or agreement with each of them. These statements were to elicit various beliefs related to respondents' health and health care. Table 14 provides a summary of their responses. While we often describe this population as one turning most often to friends for help, 60% of these women did not agree that 'acquaintance' help was better than a doctor's. Nor did the majority attribute to physicians the ability to cure them, with 55% disagreeing with the statement 'no worries – doctor can cure.' However, over 70% believed that 'God will take care' of them and over 90% agreed that there were many things they could do to stay healthy.

Most (73%) did not believe that doctors could do all they claimed they could, and 77% believed people understood their problem better than the doctor. In contrast, almost three-

quarters (74%) believed age is the cause of many health problems. Fully 86% of the women believed people who took care of themselves stayed healthy. When asked if they believed that some home remedies are better, 64% agreed, with 31% agreeing or agreeing very much with the statement.

Table 14: Health Beliefs

	Frequency	Percent
No worries - Doctor Can Cure		
Don't Agree	25	55.6
Agree A Little	13	28.9
Agree	5	11.1
No Response	2	4.4
Acquaintance Help Better Than Doctor's		
Don't Agree	27	60.0
Agree A Little	10	22.2
Agree	8	17.8
God Will Take Care		
Don't Agree	12	26.7
Agree A Little	8	17.8
Agree	14	31.1
Agree Very Much	10	22.2
No Response	1	2.2
Medicine Will Cure All One Day		
Don't Agree	33	73.3
Agree A Little	6	13.3
Agree	4	8.9
No Response	2	4.4
Many Things One Can Do To Stay Healthy		
Don't Agree	2	4.4
Agree A Little	5	11.1
Agree	32	71.1
Agree Very Much	6	13.3
Don't Believe Doctors Can Do All They Say		
Don't Agree	10	22.2
Agree A Little	10	22.2
Agree	22	48.9
Agree Very Much	1	2.2
No Response	2	4.4

Table 14: (continued)

Many Health Problems Caused By Age		
Don't Agree	12	26.7
Agree A Little	10	22.2
Agree	22	48.9
Agree Very Much	1	2.2
People Who Take Care Stay Healthy		
Don't Agree	6	13.3
Agree A Little	8	17.8
Agree	25	55.6
Agree Very Much	6	13.3
Person Understands Problem Better Than Doctor		
Don't Agree	10	22.2
Agree A Little	3	6.7
Agree	24	53.3
Agree Very Much	7	15.6
No Response	1	2.2
Some Home Remedies Are Better		
Don't Agree	16	35.6
Agree A Little	15	33.3
Agree	13	28.9
No Response	1	2.2

5.3.4.1 *Informal Treatment Actions.*

Almost all of the women (96%) reported that their families used home remedies when they were growing up. Most (68%) said they continued to use home remedies, at least some of the time; 20% reported using them all of the time (Table 15). There was not a statistically significant association between the use of home remedies, or self-care, and the five selected demographic characteristics or self-rated health status.

Table 15: Use of Home Remedies and Self-Care

Family Use Home Remedy		
No	1	2.2
Yes	43	95.6
Personally Use Home Remedy		
Never	14	31.1
Sometimes	21	46.7
All of the Time	9	20.0
Some Home Remedies Are Better		
Don't Agree	16	35.6
Agree a Little	15	33.3
Agree	13	28.9
Used Self-Care During Past Year		
No	17	38.6
Yes	27	61.4

To further understand treatment actions, the women were asked: "In the past 6 months to a year, have you had any health problems that you felt you could take care of yourself?" and "Did you do anything yourself to make you feel better either before, during, or after seeking help?" Sixty-one percent (61%) had engaged in a form of self care in the past 6 months to a year. The women offered a range of responses. Some spoke of delaying care, using self-care, or getting an over-the-counter product to treat their problem. For example:

> I used to buy them inhalants. No over the counter medicine. I would just get them.....I used to get out of breath before off and on, for years I would get out of breath, and I would get them puffers and they'd do good and I'd just go on..... (Age 70)

> Sometime when I be, you know, real bad I go and I take me a couple of Bufferin pills myself, you know. (Age 86)

I go to the drugstore a lot of times and ask them. (Age 76)

Others relied on the Emergency Department. For example:

When I get sick I just go into the emergency. (Age 68)

If I get that sick, you know, I'd go to emergency. If I had pains or something like that I'd go. (Age 68)

Another respondent used a home remedy in combination with her doctor's treatment. As evident in this respondent's comments, she gave credit to the combined treatment for her improvement:

> But there was an old lady that told me in New York if I ever have high blood pressure, she told me something to take. She told me to get me some garlic, fresh garlic and put about three of them little cloves..... in a quart jar of water and get a lemon and squeeze all the juice out of that lemon and strain it and put it in that quart of water and drink it. And I did. I took the doctor's medicine and I'd take me a big swallow about three times a day and you know my pressure went down. (Age 79)

The trust, loyalty, and faith in one's doctor shaped, and in one case discouraged, self-care strategies. For example:

> When I get sick I see a doctor. I don't believe in treating myself. I believe in the doctor and I follow his advice. (Age 85)
>
> He always said don't go into (ER), I mean, don't see other doctors or go into that without his consent, so I just stay away from there. (Age 84)
>
> I don't usually, I mean, I don't interfere, whatever he does, I mean I never do anything without consulting him about it, so, he's been my doctor for a long, long, time. (Age 84)
>
> I get sick I see a doctor. I don't believe in treating myself. I believe in the doctor and I follow his advice. (Age 85)

Other respondents had less confidence in their doctor's ability to help them, leading to their own treatment actions. There seemed to be an expectation among some that doctors should give medicine or take some significant action in the face of a health need. When this expectation was not met, these women were likely to take action on their own. She stated:

> They (health provider) didn't do nothing. They just bind it up. Didn't give me no kind of medicine. They just put a little cast on, and I just took the vinegar and I poured the vinegar on it at times and then I'd take (drink) the vinegar. (Age 70)

While some might classify responses about the use of prayer as a religious belief, I believe that 'prayer' also serves as a form of informal treatment or self-care. Individuals turn to prayer often in combination with seeking formal and informal care. Therefore, I have included those responses in this section. For example, one respondent talked clearly about the value of prayer but also stressed seeking medical care when needed:

> God is in his place, uh, and the doctor has his place. But saying I can pray and get better. Prayers, I like prayer meeting but it's no good in the bedroom, huh-uh. No, I believe that you have to have medical help. (Age 82)

Others expressed strong faith in God, and believed that he often works through the doctors. For example:

> I go to the doctor to help me to get cured. I think God cures me. I believe in God as the head of the curing. He tells the doctor what to do and give him the knowledge of taking care of my problems. But without God I don't think the doctor would do nothing. I believe in God as the head of it, doctor, give him knowledge to do what is good for me. I think God is the head of that. I believe the God is the head of me getting well and prospering with my health. I pray every day for Him to take care of me and help me to get well. I think it's God that helps you, He gives the doctor the knowledge to give you the medicine to help you. That's my belief. The doctor can't do anything without the help of God, that's my belief. I pray to God, I don't pray to my doctor. (Age 82)

> Yeah, I have great faith in the Lord and I have faith in the doctors and the nurses. Listen, if you go no faith in the doctor why go to him? You have no faith in the nurse why let her bother me, cause you'll make her miserable and you're miserable yourself. (Age 77)

> Can I say this? It may not make sense for this kind of thing, but do you know I call upon the Doctor way up, up. I ask God to guide my actions and my thoughts or even a doctor, cause see I don't know a whole lot about that. God puts doctors and He, He helps doctors. (Age 81)

Another woman described her doctor – who is also a preacher – making a home visit. This combination seemed to be reassuring to her:

> Dr. R came to my house to see me. He said our prayers, and he come in to see me that Sunday, saved my life. He had this Bible, too. You don't see very many doctors believe in the Bible. (Age 77)

These respondents illustrate the diversity in health beliefs and practices that are often passed down through generations, stemming from cultural tradition and norms. Many of them believed that taking care of themselves does help them to stay healthy; yet there were times when they sought assistance from health professionals and the formal health care system.

5.3.4.2 *Formal Treatment Actions.*

While they were not asked specifically about having a particular 'acute' illness, the women in the study were asked: "In the past 6 months to a year, have you had any health problems that you sought help for?" Overall, 35 (70%) had recently sought help for a health problem. In general, most women spoke about chronic conditions, acute episodes of chronic conditions, or acute conditions that seemed to become combined with the care of their chronic problems as they described them. There were no statistically significant relationships between involvement with a formal health care provider and the selected demographic characteristics or self-rated health status.

Formal treatment actions can be influenced by prior experiences with the health care system as well as by personal preferences regarding physician characteristics. The women were asked: "Have any of your (regular doctors) been Black?" "Would you rather go to someone Black?" "Have any of your (regular doctors) been women?" "Would you rather go to someone who is a woman?"

Most of the women indicated they did not care about the race (82%) or gender (64%) of their doctor. Almost a third (31%) of them had never had a Black doctor and 18% had never had a female doctor (Table 16). There was no significant relationship between provider characteristics and whether or not respondents had sought help for a health problem during the preceding six months.

Table 16: Doctor and Preferences

	Frequency	Percent
Any Doctor Black		
No	14	31.1
Yes	31	68.9
Prefer Black Doctor		
No	3	6.7
Yes	5	11.1
Don't Care	37	82.2
Any Doctor Female		
No	8	17.8
Yes	37	82.2
Prefer Female Doctor		
No	5	11.1
Yes	11	24.4
Don't Care	29	64.4

There was no significant relationship between self-rated health status and preference for Black or female doctors, or having had a female doctor. There was, however, a significant association between self-rated health status and having had a Black doctor (Table 17). Almost two-thirds (65%) of those who rated their health status as good or excellent, compared to 36% of those rating their health as fair or poor, had received medical care from a Black provider.

Table 17: Doctor Preferences by Self-Related Health Status

	Poor/Fair N (%)	**Good/Excellent N (%)**	**Chi-Square**
Any Doctors Black			7.17*****
No	11 (78.6)	3 (21.4)	
Yes	11 (35.5)	20 (64.5)	
Prefer Black Doctor			0.31
No	1 (33.3)	2 (66.7)	
Yes	4 (80.0)	1 (20.0)	
Don't Care	17 (45.9)	20 (54.1)	
Any Doctors Female			0.005
No	4 (50.0)	4 (50.0)	
Yes	18 (48.7)	19 (51.4)	
Prefer Female Doctor			1.90
No	1 (20.0)	4 (80.0)	
Yes	6 (54.6)	5 (45.5)	
Don't Care	15 (51.7)	14(48.3)	

**p*≤*.05*

For many respondents, however, more important than gender or race were perceptions of positive care provided by the doctor and/or staff:

> The color has nothing to do with it, it's the way they treat you. (Age 74)

> I'll tell you, they all alike when I like them. (Age 77)

> I would rather go to anybody that can do me any good. I'm not prejudiced like that. (Age 68)

> It doesn't make me any difference. When I first retired I started going over to U Hospital that was one of the best doctors I ever had, Dr. M. She was White, and I just let my sugar just go any kind of way, got fat.....200 pounds, and she said: Now you're goanna die. She upset me so bad. And then the next morning I said you shouldn't have told me that I was gonna die, she says: We're all gonna die but you're hurting yourself, she says. Next time you come bring a member of your family and I'm gonna tell them how you do not do what I told you to do. (Age 71)

Although one respondent referred to what is commonly known as the under-representation of Black physicians in the health system, others accepted who they got, given their situation. For example:

> I want to go to someone who can take care of me. I don't care whether they're green, purple or red. But in the hospitals where I have been there haven't been any there. And when I was referred to the different doctors they were all white doctors. But now I'm not adverse about it, but under the circumstances there wasn't any one there. I'd like to see more Blacks. I wish there were more Black doctors. All of my regular doctors have been women so right now I would say yes (prefer women). (Age 84)

> I guess I, well, you know, I never thought about it. I, I, really, I really never thought about it but I guess I would prefer Black. (Age 74)

For some, female physicians were preferred because they were seen as having a better understanding of female issues. However, there was also an expressed or implied perception of the inferiority of Black or female doctors on the part of some women. For example:

> Never had a female doctor. It doesn't, never mattered, you know. I mean, I just have more confidence in a man doctor. (Age 70)

> I don't want no Black doctor. I don't think they know enough. I know other people went to them and they didn't help them, so I said no, I don't want to get tied up with no doctor. (Age 80)

> We all got along and they all pleased me. I don't know why I prefer men doctors. You know why, because that's all I've been used to all my life. (Age 77)

As discussed earlier, several respondents believed that God works through the doctor or is in control of the situation. Therefore, preferences about the gender or race of the provider were of less importance:

> I don't care who he is long as... I pray all the time. I'm a praying woman [laughs], that's what I am. 'Cause whatever I get I thank the Lord for and then I pray and the Lord will bless my soul. No preference because I believe it is up to the Lord. (Age 76)

> You know I hadn't even thought about that. If he's a good doctor and he's Black, it's fine with me, you know, whatever. I think I would feel that either race is.....I don't know, I think that God would give me the feeling to know. (Age 70)

Finally, the women were asked: "In general, have you been satisfied with your regular source of health care?" All but one of the women was satisfied with her regular source of health care. To further understand their responses, the women were also asked, "Did you feel your doctor was concerned and willing to listen to you? Did you have confidence in (doctor)? Did you think (Dr. ___) was a good doctor? Did (Dr. ____) or staff make you feel uncomfortable in seeking help? If so, in what ways?" Good care was most commonly seen as doctors showing, by their words and actions, concern and compassion for the woman. For example:

> Whenever I go they all seem like they glad to see me because I try to use common sense, you know. (Age 77)

> I have a doctor now. She seems concerned. I had it (Pap test) all because she insisted on all of them. (Age 81)

> But they keeps a watch on me. Any time they think I need therapy they will call me in for therapy. They want to keep me walking. They don't want me to get in the condition I got in, and I was like that for a few years, you know, come down like that. I praise them, they're good. They've done great things for me. (Age 77)

> They seem to give me, um, you know, they give me good, they pay good attention to me and if I tell him something he'll sit down and explain to me, you know, the best of his knowledge what he thinks I can understand. Cause he always say now, do you understand, do you understand? Like when I have to go and take a

> mammogram, he always make the - which he's supposed to - the connection for me with, whatever, um-hum. (Age 82)

For some, their experience of formal medical care was imbued with a sense of powerlessness and the perception that the doctor (or staff) did not value their opinions or value them as a person. Several attributed this to a lack of respect for the aged. For example:

> I don't think any doctor's concerned to listen to older people except for Provider B. They seem to. I guess that's what they're specializing in older people, but most of the doctors I think don't care too much. (Age 81)

> When you get a certain age they think you should die. My husband, he went to this private doctor and they knew he had an obstruction or something. They said well, he's too old to be operated on, but they never did anything. So then I had got him into the hospital and they discovered he had this colon cancer. (Age 81)

Some of the women tried to communicate important issues about their bodies or their health conditions to the medical staff, but were unsuccessful. For example:

> I told the girl when I had the x-ray, you know, I always try to warn them, you know, when you do a regular chest x-ray I told them, I says now then you do this x-ray I only have one lung. And you know, you warn them, you know, 'cause they, so they will know. And, uh, undoubtedly she didn't believe me cause she took x-ray this way, x-ray that way, x-ray this way, and she kept taking them over and over and over again. So, uh, she'd go with that one and she'd come back and she'd take them again. So I guess finally it dawned on them that maybe what I was telling them was the truth. Yeah, but they charged me. I had to pay for a whole lot of x-rays that they didn't need because, uh, the insurance wouldn't pay for it. (Age 68)

> One day I kept telling them about it, telling them about it, and they just looked at me like I don't know what I'm talking about. And one day the doctor was examining my heart and my heart skips a beat when it's, you know, hurting. And he said 'Did you feel your heart skip that beat?' I said all the time. I said that's what I'm trying to tell you about this *tic de laru*, it makes my heart skip beats, that's how bad it is. So right away they went and dug in the books to see what it was and get me some medicine, and told me 'I don't see why they haven't been giving it to you all the time.' I said I been trying to tell them. (Age 67)

Another woman perceived her doctor as insincere and as not having enough time for her as a patient. She described behavior that might be viewed by others as 'personable,' but which she interpreted as dismissive. Her perception of her 'family doctor' was interesting in that she was turned off by what some might consider 'good bedside manner':

> Dr. D was a family doctor, and I don't like that. He would come in and say: Oh, Alice, how nice you look. Kiss me on my forehead say: You're doing fine. I'm not going to the doctor for that, I'm going to the doctor to give him my complaint and....and he kept...see he has a large turnover in patients and he's working so fast, and I didn't think he spent enough time with me. And he's just saying this, using psychology or psychologic to just make me feel like I'm good. I felt that he was just too busy really to take the time. His office was always full of people and being in a hurry trying to take care of everybody. (Age 76)

Since the rules for patient/provider behavior and communication are not always explicit, conflicts, misunderstandings, and mistrust can occur. Perceptions of care appear to be based on the patient's expectations. These expectations may relate to the respect shown to the patient, how a provider and staff demonstrate concern, the interaction between the provider/staff and the patient, and shared beliefs, gender, and race.

5.3.5. Adherence

The final conceptual element in the health-seeking process is adherence, or the degree to which the sick person acts upon treatment advice (Chrisman, 1977). To assess adherence, the women were asked: "Did you follow the advice you received?" Given that the respondents expressed a good deal of loyalty and trust in their doctors, one might assume that their adherence would be high. However, there was some variability related to the issue of adherence among these women.

The responses illustrated the range of meanings captured by the term 'adherence.' Some of the women acted in complete and full accord to the treatment recommendation, while others made individual choices about what advice to follow and how much medicine to take. Some combined formal treatment plans with their own self-care strategies. For example:

> I do what the doctor says. That means do exactly what they said, the way they want it done. (Age 85)
>
> Whatever the doctor told me, I just did it, to a certain extent. (Age 81)
>
> I have a cataract, I had this side done but I haven't had this side done for my cataract. And I just went, I said what's the use to getting my eye done if my heart's bad and my kidney's bad, I'm not gonna be here that long. (Age 76)
>
> I don't believe in a whole lot of pills. Maybe I'm wrong for saying it. See, I can't take a lot of strong medicine. I almost use my own judgment about that. And that's bad I guess. But what helps me is like you say, take three a day, I'll say like take two a day and I'm well helped. And I don't believe in too many medicines at one time. I don't know whether that's good or bad but I do well so far. Cause all that chemicals get in your stomach. That's just me. (Age 74)

The interviewer then asked her: "So you're saying that you'll reduce the dosage?" The respondent replies:

> I guess you would say that, uh-hum. I don't tell them that, though [laughs]. (Age 79)

One woman described how loss and grief influenced her decisions about taking her medicine and following the doctor's advice and treatment plan. In this instance, her decision not to adhere was directly related to her mourning her husband's death:

> Only when I didn't take my medicine right and he got a little miffed. But I didn't listen to the doctor cause I didn't care. I was doing like I wanted to do. I was worried and upset so

> I didn't care whether I lived or died. I didn't want to live to tell you the truth. The first time I wanted to die since my husband died. It was in November and I tried to too and I almost did. (Age 82)

Adherence was sometimes prompted by fear based on the consequences of not following the doctor's advice. For example:

> If you'd see my medication you'd know why. They said that I could so easily kill myself, mix the wrong thing up there. So they got everything written, got papers written all around here. This is for this, this is for that, you take this time, you take ... and if I follow it closely I won't go wrong. I haven't went wrong yet. (Age 77)

When faced with decisions about medication management, some respondents made choices based on their own beliefs about becoming overmedicated or dependent. For example:

> Anytime they prescribe something for me I take it, but I, uh, whenever I, um, take medication and the minute that I feel better I go two or three days, then I don't stay on it cause I don't want to get myself adapted to have to take drugs every time. Soon as I feel better then I stop taking, so that's why I got all that stuff left in there now. [Laughs] But I think you can be overmedicated. (Age 77)

> Sometimes a doctor's medicine will kill you. God heals. He has brought me from a mighty long ways. I have laid here in this house by myself sick unto death. You'd think I wouldn't live to see day, and I'd just say Lord, I'm in your hands. If it's Your will, I'll be here tomorrow when day comes. (Age 87)

Perceptions regarding the quality of care, which were presented in the prior section, can play a significant role in influencing whether or not patients get preventive or follow-up care. For example:

> Well, I have a lady doctor but she don't -- she acts like I'm poison, she don't touch me, so I don't go to her. She's supposed to be my regular doctor. I went to her for my heart problem. She acted like she didn't want to touch me. She didn't even come over to see if my heart was beating or anything. So I said I'm not going back to her no more, and I don't. I didn't even get a flu shot because I didn't want her to give me none. (Age 70)

> I don't ask them nothing. I just listen to what they say, I never ask nothing. I have a roaring in my head all the time, it feels like, uh, and I asked him, said, oh, there's nothing we can do about that, so I've never said anything more about it. It's very annoying. It's in my head and it's like roaring. I have it constantly. At night it gets so I don't sleep good on account of it. (Age 81)

Clearly, there are numerous reasons for adhering or not to a treatment plan. These women confirmed and supported much of what we have learned over the years about adherence being influenced by one's personal experience, health beliefs, self-determination, and trust, or lack thereof, in the provider or the plan itself.

5.4 SUMMARY

This chapter presents, in detail, the results of the study. It begins with several tables displaying the demographic characteristics of the women. I then assessed those characteristics in relation to perceived health status and found potential predictors of health. Further, the chapter describes the study results related to the Chrisman (1977) model (symptom definition, illness shifts in role-behavior, lay consultation, treatment actions, and adherence). Qualitative analyses allowed the voices of the women themselves to give meaning to these variables. Finally, the chapter presents the results of Chrisman-related variables in relation to the women's self-perceptions of health.

6.0 DISCUSSION

The purpose of this study was to further the understanding of health behavior among older African American women. This was done by examining and describing the themes related to health behavior among a group of 45 elderly Black women who participated in the National Institute of Aging supplemental study entitled *Health Behaviors of Older Blacks*. During the supplemental study, the women were interviewed to obtain information on socio-demographic, psychosocial and health behavior measures, including perceptions of care, race and gender preferences, health beliefs and health practices. In conducting an analysis of secondary data, I looked specifically at self-related health status in relation to several selected demographic characteristics and other health behavior measures. Additionally, I used the key concepts of the Chrisman (1977) model as the framework to understand the qualitative data.

This chapter begins with an assessment of the major findings of the study. I then discuss the strengths and limitations of the conceptual framework. This is followed by a discussion of the study's limitations. The chapter concludes with a discussion of the implications for social work and future research.

6.1 INTERPRETATION OF MAJOR FINDINGS

The women in the study were interviewed to obtain information on socio-demographic, psychosocial and health behavior measures. The quantitative measures were examined in relation to self-rated health status and the qualitative responses were organized around the Chrisman (1977) concepts.

6.1.1 Demographic Characteristics

I selected several demographic variables to examine: age, education, income, living arrangement, marital status and self-rated health status. A separate section on self-rated health status is presented.

In a recent study, Musa et al. (2003) found that the highest proportion of the older population in Allegheny County is 65-69 and 70-74 in the City of Pittsburgh. The mean age of the women in my study, interviewed in 1993 and 1994 was 77 years. The modal ages were 67 and 74.

Most of the respondents in this study had gone no further than the 12^{th} grade, with the mean years of education being nine. Only four had post-high school education. These results appear to be consistent with Taeuber's (1992) finding that over half of all elderly Blacks (57.3%) have completed less than 9 years of formal education and are less likely than elderly whites to have completed either high school or college.

Almost half (42%) of the women reported an annual income less than $5,000 and 57% reported an income between $5,000--$10,000. Only one woman received over $20,000 annually.

These findings are consistent with Musa et al.'s (2003) more recent findings regarding older Black women in the City of Pittsburgh, who were among the poorest of the City's population.

Sixty-four percent (64%) of the respondents reported being widowed. Approximately 18% were divorced; 13% were married; and 4% reported having never been married. The majority (64%) of the women interviewed lived alone, while 20% lived with a spouse. Perhaps some women were living with a partner they were not married to but whom they identified as their spouse. Additionally, 16% reported living with someone other than their spouse. These findings related to marital status and living arrangements are also consistent with the results of Musa et al.'s (2003) newer study. Approximately 76% of Black females in the Musa et al. 2003 report were not married. Additionally, 60% of the Blacks in the Musa et al. (2003) sample lived with others and 41% lived alone.

6.1.2 Self-Rated Health Status

The second question assessed in this study related to influences on these women's ratings of their health status. Approximately, fifty-one percent (51%) of the respondents rated their health as poor/fair and forty-nine percent (49%) said it was good/excellent. The Forum (2000) report indicates that asking people to rate their own health provides a reliable indicator of health status. Self-reported health status represents physical, emotional, and social aspects of health and well-being. Good to excellent self-reported health correlates with a lower risk of mortality (Forum, 2000).

Although not statistically significant, the youngest age group in this study's sample characterized their health more negatively than did the older respondents. Income was the only

demographic variable that was statistically related to self-rated health status. Respondents reporting higher income were more likely than those with lower income to report their health as good/excellent. In fact, respondents reporting the high income category were almost seven times more likely to than those in the lower income category to rate their health as good/excellent.

Those who reported no bodily pain or emotional problems were most likely to rate their health status as good/excellent and, as might be expected, the higher the self-rated health, the less often were health troubles reported as standing in the way of the respondents doing things they normally did. There was a significant inverse association between self-reported health and obtaining health information from a relative. The healthier the respondent rated herself the less she tended to obtain health information from a relative. There was also a significant association between self-rated health status and having had a Black doctor, with the majority of the women who rated their health status as good/excellent having received medical care from a Black provider.

6.1.3 Health Beliefs

When asked about a series of health-related beliefs, most respondents agreed at least 'a little' that: God will take care of them; there are things one can do to stay healthy; many problems are caused by age; people who take care of themselves stay healthy; persons understand their problems better than the doctors; and some home remedies are better than formal care. In fact, when asked if they believed there were things 'one can do to stay healthy,' respondents described a variety of self-care rituals. In contrast, most did not believe that doctors can cure all; that acquaintance help is better; and doctors can do all they say they can.

A strong faith in God was expressed repeatedly, along with the belief that the doctor was simply a vehicle through which God worked to protect and heal them. Yet, even with strong faith, the respondents stressed seeking medical care when needed. One particular study included 682 eastern North Carolina women aged 40 and over who were interviewed in their homes about religious and other beliefs about breast cancer, screening, and intended actions with a self-discovered breast lump. The results indicated that a majority of women believe that God works through doctors to cure breast cancer and this 'religious intervention' may explain why African American women delay seeking treatment for breast lumps. The authors suggest that clinicians and clergy work together within the context of religious beliefs to enhance early detection and survival from breast cancer (Mitchell, Lannin, HF, & Swanson, 2002).

6.1.4 Application of the Chrisman Model of Health-Seeking Behavior

While there was no stated hypothesis associated with this study, I used the Chrisman model (1977) of health-seeking behavior to provide the framework to explore the respondents' health behavior experiences. This model appears to be a useful organizing framework. Each concept was relevant to the analysis and the responses were easily organized into the different components of the model. On the other hand, there appears to be some overlap in the meaning of the model's concepts as some responses could possibly fall into more than one category. Although the responses referenced both chronic and acute conditions, I specifically found that: (a) the women most often provided responses that included behaviors related to their health in general and not necessarily a health-seeking process connected to one specific illness response; (b) their responses suggest that they may integrate symptom complaints and descriptions of behavior related to acute conditions with those related to chronic ones; and (c) their responses

also suggest that older adults may integrate issues related to both aging and health when talking about their health experiences, concerns, and needs.

6.1.4.1 *Symptom Definition.*

The majority of the women indicated they had sought help for some problem during the six months prior to the interview. Although symptom definitions included both chronic and acute conditions, this distinction did not seem to alter the women's descriptions of how problems came to their attention. The two most common reasons for seeking help were: (1) a persistent stomach problem (98%) and (2) pain (93%), followed by headaches, forgetting often, and being unable to get around. Thirty-three percent reported having severe bodily pain during the five weeks prior to the interview and 20% reported having no pain during that same time period. Others reported at least mild bodily pain. While most women indicated that 'being sad' was not a reason to seek help, almost 27% reported experiencing emotional problems 'quite a bit' or 'slightly' during the five weeks preceding the interview.

Giving attention to pain as a motivating reason for seeking help is important. While there is no physiological basis for a decrease in pain with increasing age, pain is believed to be less prevalent among the aged and is historically underreported and undertreated (Bernabei et al., 1998). Yet, if pain is one of the primary reasons Black women seek formal care, as it was in this study, then the health care system must be responsive to that pain and view this as a possible entry point for addressing preventive health needs and managing chronic conditions. Also, as earlier research indicates that the relationship between pain and depression suggests that elderly patients with depression are more sensitive to pain caused by the coexisting physical condition

(Parmalee, Katz, & Lawton, 1989) this may have other implications for treatment and intervention.

Respondents reported that some problems were brought to their attention by others. They also were aware that changes and limitations they were experiencing might signify a problem. However, the existence of symptoms did not necessarily lead to seeking help**.** The women appeared to be making a decision based on some personal assessment of the problem and its need for formal care.

6.1.4.2 *Illness-shifts in Role Behavior.*

Most of the respondents indicated that their health troubles stood in the way of doing chores, with most attributing this limitation to some physical cause. Bodily pain or being incapacitated in some way seemed to precipitate the interruption of their routines. Respondents described normal and routine activities, such as chores and social events, with which their health problems interfered. The higher the income, the less often women reported that their health problems interfered with social activities and routine chores. It appears that having access to money may also provide the resources to prevent 'illness-shifts' from becoming a barrier to maintaining one's normal routine and social activities.

Not being able to attend church appeared to be a common signal of role-behavior shift as a result of illness. This finding speaks to the significance Black women place on their role as 'church member.' This finding is consistent with other research studies; for example, Musgrave et al. (2002) suggest that the Black church plays a unique and vital role in the lives of Black women, serving as a source of spiritual renewal, practical support, and community.

6.1.4.3 *Lay Consultation and Referral.*

One theme commonly expressed among the women in this study, was their confidence in their doctors which led them to limit consultations about their health to him/her only. Although much of the literature (Boulware, Cooper, Ratner, LaVeist, & Powe, 2003; Gamble, 1997; Smith, 1999; Wolff et al., 2003) reports African Americans mistrusting the health care system, my analysis, as well as the findings of two earlier studies, indicates this does not seem to be the case for African American women living in Allegheny County.

Almost all of the respondents in this study reported health care personnel as a vital source of their health information and advice; in fact, health care personnel were the source identified as providing most of their information and advice. Interestingly, this is not a new finding. Gallop (1997) and Musa et al. (2003) both had similar findings conducting research with older adults living in Allegheny County during two different time periods. Gallop (1997) reported that participants identified their medical doctor as the preferred source of health information and that they were felt comfortable asking their doctors about health matters. Physicians were also considered the most believable source of information. Similarly, Musa et al. (2003) found that almost all of the Black females characterized their physician as their most trusted source of health information

Freidson (as cited in Loustaunau & Sobo, 1997) suggested that when people become ill they first turn to family and friends, then to suggested lay 'experts,' and finally, if nothing works, to a physician and the biomedical system, although lay norms may influence this option. However, the older population, represented both in this study and the Musa et al. (2003) study, seem to put more trust and faith in their health practitioner than in family and friends. Perhaps

this is because older adults are dealing with more chronic, disabling and life threatening health conditions that require direct medical attention for quality of life and survival.

The church was not among the most common sources of information. Perhaps this is because at the time of these interviews (1992) the faith community was just beginning to promote health and establish health ministries. Therefore, older adults, while trusting their church and religious leaders in many ways, may have seen them as outside the network of health care, advice, and information. Furthermore, they may not have been as connected as younger adults to the health-related activities that have occurred in the faith community in recent years, especially if these activities were not age and gender specific.

The notion of 'advice' appears to be very subjective, with respondents frequently indicating they did not seek advice, but then adding that they did speak to friends or family about the problem. They appeared to distinguish advice-seeking from general discussions with whom they often share information and suggestions related to health problems, health care, and health practitioners.

Respondents in this study indicated that when they consult with or seek advice from family or friends, they are typically advised to contact their doctor. This finding is also consistent with the notion advanced earlier by Neighbors (1988) which is that families and friends do not necessarily hinder referral to formal systems but often times encourage it.

6.1.4.4 *Treatment Actions.*

While almost all of the respondents reported their families used home remedies when they were children, about 68% of them still use them now, with 20% currently using them 'all of the time.' Another 31% never used home remedies at all. When asked if they thought home remedies were

better, over 60% agreed and had used some form self-care during the six months preceding the interview. Based on these responses, I think we can assume that the majority of the women interviewed continue to use self-care (home remedies) consistently with their medication and perhaps even instead of formally prescribed medication.

Delay in seeking care and using self-care instead was a common theme, as was combining informal and formal treatment. Self-care treatment actions represented a way of stretching resources and of addressing concerns they thought were not serious enough for formal care. They were also used when respondents perceived the doctor's treatment or care as not living up to their expectation. On the other hand, some women clearly stated that using their own treatment actions meant interfering with the doctor's care; because of the faith they have in their doctor, they would not use a self-care option while following the physician's regime.

Janz and Becker (1984) suggested one way of analyzing self-care practices is through two elements of the 'health belief model': perceived susceptibility to disease and perceived efficacy of physician care. Individuals who perceive their health as good and who are not plagued by psychological distress would have confidence in their own resilience and be ready to care for their ailments without resorting to professional help. Conversely, individuals who have chronic conditions or who experience a high number of symptoms could view themselves in poor health and in need of doctor's advice. In brief, positive health facilitates self-care (Haug, 1991). Given the often chronic health issues dealt with by this study's respondents, their reliance on physicians and ambivalent use of self-care strategies appears consistent with Jazz and Becker's formulation.

Becker et al. (2004) found that cultural values and practices are embedded in a variety of African American social institutions, including the family and the church, and encompass

spirituality, social support, and traditional, non-biomedical health and healing practices. These emphases are central to self-care (Becker et al., 2004). This is evidenced in the way the women in this study described an integration of informal and formal treatment actions that ranged from home remedies and prayer to the trust they have in their physicians as a source of information and care.

All of the women in the study indicated an affiliation with the formal care system; the majority of the respondents (70%) had sought help from some part of that system during the six months prior to the interview and most reported having gone to the emergency department. Respondents talked about individuals in their lay referral system encouraging them to seek the help and advice of a formal health provider. This would lead us to believe that there is a level of confidence in the formal care system, at least as it relates to the care of older adults. As a result, families and friends are not necessarily barriers to older adults accessing formal health care, but instead they encourage its use.

Over 80% of the women indicated that they 'don't care' about the race of their physician, and 31% of them had never had a Black doctor. Some who have never had a Black doctor expressed a desire to have one or thought it might be nice if there were more available.

Respondents talked about their preference for female doctors because of the perceived empathy and compatibility on the part of a female physician. Eighty-two percent had gone to a female doctor, although 64% said they 'don't care' about the gender of their doctor. One woman stated that she had more confidence in male physicians than in female doctors.

More important than gender or race were perceptions of care. Wykle and Haug (1993) propose that if perceived efficacy of professional care is negative because of a previous experience of medical error or an attitude of skepticism about the values of a physician's

treatment, the symptomatic person is likely to prefer self-care. In other words, a low evaluation of doctors favors choosing self-treatment and distancing oneself from the formal system (Wykle & Haug, 1993).

Respondents stressed wanting good care from whoever provided it, regardless of race or gender. Comments expressing negative perceptions were related to ageism, and the doctor not listening or valuing their opinion and awareness of their own bodies and not taking enough time with them. On the other hand, when expressing positive perceptions of care, the respondents made comments such as: "they all seem like they glad to see me," "she seems concerned." Respondents also admitted getting screenings done or adhering because the doctor showed concern by 'insisting.' Respondents often spoke of 'they' when describing their perceptions of good care, indicating the importance of the medical or office staff in building trust and relationships with patients.

This finding is consistent with studies have found that satisfaction with physician care is linked to a range factors including perceived competence and attitudes of providers (Goldwag, Berg, Yuval, & Benbassat, 2002) as well as patients' perception of the relationship, level of trust, providers' answering questions, provision of adequate information, and patients' feeling of being involved in decisions about their care (Nerney, Chin, & Jin, 2001). Becker et al. (2003) argue that the research to date identifies multiple factors that affect patient satisfaction, with SES being among the most significant because it dictates the sector of the health care system in which people receive care. The authors stress the importance of considering both ethnicity and class since findings based on just one of these variables may be misleading (Becker et al., 2003).

6.1.4.5 *Adherence.*

While many women spoke of doing exactly what the doctor instructed, adherence to instructions appeared to be related to the respondents' perceptions of care and their relationships with their doctors. Adherence was influenced by several factors, including trust in the doctor, relationships with the doctor's staff, fear, health beliefs related to the treatment, and beliefs regarding medication. As a result, while some women might adhere completely, others integrated their own treatment for the problem or made their own judgment about the degree to which they would adhere.

These findings support research reported by Loustaunau and Sobo (1997) who suggest that the reasons for non-compliance (or non-adherence) are varied, but the rejection of or failure to act on instructions is generally not due to a patient's uncooperative nature or ignorance, as some doctors conclude. Communication between the patient and health provider can influence a patient's decisions to follow treatment plans or get preventive care (Loustaunau & Sobo, 1997). According to the Loustaunau and Sobo (1997) one measure of communication is how much information gets transmitted. Research examining patient race/ethnicity and quality of patient-physician communication during medical visits found physicians were more verbally dominant and engaged in less patient-centered communication with African American patients than with White patients (Johnson, Roter, Rowe, & Cooper, 2004). In this study, for example, one woman stopped mentioning her symptoms because her doctor had indicated there was nothing that could be done. However, her response indicated that she didn't know the cause of the ringing in her ears, so that information was perhaps never communicated to her or she didn't understand the explanation.

What we learned about perceptions of care in this study adds to our knowledge base about how such perceptions can influence health behavior and practices. These findings highlight the importance of the relationship between patients and health care personnel. According to Ditto and Hilton (1990), health care decisions and behaviors are inherently social. Help-seeking involves not only the decision to seek treatment, but also the decision to enter into a social interaction with a health care provider. The interpretation of ambiguous symptoms, the beliefs about the severity of a disease, and the costs and benefits of its treatment can all contribute to a delay in help-seeking (Ditto & Hilton, 1990). In this study, positive perceptions of care were expressed about both White and Black providers, as well as male and female providers. Thus, among this group of respondents, it appears that valuing, respecting, and reflecting sensitivity to older adults as individuals with individual and diverse needs carries a great deal more weight than either race or gender. However, there was also some indication that if given a choice, some women would choose a doctor who looks like them and has a shared cultural experience, including spirituality.

6.2 THE UTILITY OF THE CONCEPTUAL FRAMEWORK

6.2.1 Strengths

Although the process itself, described by Chrisman (1977), could not be applied to this analysis, the model proved to be quite useful in providing clear and concise concepts for organizing, framing, and analyzing the responses to the questions asked during the study interview. These concepts (symptom definition, illness-shifts in role behavior, lay consultation and referral,

treatment actions, and adherence) were used to explore the health-related behavior of the respondents and then for coding and categorizing their responses to the interview questions.

6.2.2 Limitations

Initially, I believed, based on the survey questionnaire and its intended focus on acute illness that this study provided an opportunity for the process of the Chrisman (1977) model to be applied and examined. However, once I read the interview transcripts it became clear that: 1) the respondents had not consistently distinguished between acute and chronic conditions when responding; and 2) their responses were not always related to the condition(s) they had originally identified as the problem. These two issues made it impossible to analyze a specific 'process' retrospectively; however, it might have been possible to access Chrisman's proposed process if the study were designed specifically to examine it. Therefore, what I did instead was to use the concepts of the Chrisman model to explore the health-related behaviors of the women in the study. My suggestions to potential users of the model, is to not be discouraged by the age of the model or the fact that it has not been widely publicized. The concepts of the model are applicable to diverse populations and health conditions, making it useful for analysis and application. I would caution you, however, to consider the cultural implication and translation of the terms (i.e., advice).

6.3 LIMITATIONS OF THE STUDY

The sample was a small; while over 137 African Americans participated in the parent study, a much smaller number agreed to participate in the supplemental study (67 females, 6 males).

Only forty-five (45) of the females and two (2) of the males actually completed the interview. I further reduced the number by focusing on the 45 women. As a result, it is possible that marginally significant findings may surface as significant with a larger sample.

This study relied upon secondary data; given the small sample size, there were limits to the kinds of statistical analyses that could be conducted. The ability to generalize the findings is restricted due to the small sample size, the fact that the sample is not representative of the general population, and the cross-sectional nature of the study. The data illustrate the reported and observed behavior as a snapshot at a particular point in time. Obviously the sample size was a small to use logistic regression (LR); however, the goal for doing this analysis was to determine whether these variables predicted health status. The LR test, similar to the Pearson Chi Square, was used because it is considered the most accurate given a relatively small sample size (Hosmer and Lemeshow, 1989).

Also, while I have examined the data, I was not a part of the original research team conducting the study and I did not conduct the interviews. Thus, there were responses that, from my perspective, warranted further probing, exploration, and clarification. Had I conducted the interviews myself, I would have approached such instances differently.

6.4 IMPLICATIONS FOR SOCIAL WORK PRACTICE

The Black helping experience and cultural norms and traditions reinforce the need for social workers and other formal helpers to develop not only an awareness of and sensitivity to these issues, but also skills that will allow them to work effectively and respectfully with this population. Social work as a profession is a strong advocate for understanding and valuing

human diversity in health beliefs, health behavior, and illness behavior among consumer populations, while, at the same time, developing national standards for the delivery of culturally competent practice, service and care. Historically, social work has had a unique perspective on women's issues, with social justice being the hallmark of the profession. From the beginning, women have been major players on both sides of the social work profession – both as workers and as clients. We have powerful foremothers -- Jane Addams, Bertha Reynolds and Mary Richmond – who, from the earliest days, provided strong leadership in developing strategies to meet the needs of persons who were oppressed, most of whom were women and their children (Land, 1995). Clearly, Land (1995) reports, these women helped define social work and were much concerned with disenfranchised groups and women's issues.

The social work profession also attempts to see where elements in the interactions between clients and their environment are causing problems. Neither client nor the environment is seen as having problems necessarily; it is the interaction between them that might be difficult (Payne, 1991). Social workers have been and continue to be committed to creating a service environment that is both culturally competent and client centered, focused on enhancing the interaction between the clients and their environment.

Cultural competence has been associated with improved healthcare services, such as increased client satisfaction, decreased rates of non-compliance, and increased effectiveness (Campinha-Bacote, 1991). For the provider, the patients whose needs are most difficult to meet are those whose belief systems are most different from the mainstream health care provider culture. Ordinarily, the provider knows little about a client's self-perception or beliefs regarding health and illness; therefore, care providers have to engage the patient in a way that integrates a

discussion of that patient's perception of the health problem, its causes, and its treatment (Greene, 1995).

Greene (1995) adapted much of his work related to cultural competence and help-seeking behavior from the previous work done by Arthur Kleinman (1978) and others. Greene (1995) identified three basic assumptions of a model for working with culturally diverse clients:

1. Language is of special importance since it is the symbolic way an experience is categorized**.**

2. Any need or problem is both a personal and social event.

3. There is a fundamental dichotomy between illness and disease.

Hence, people's notions of care are socially constructed, based on a system of communication that includes language, procedures, and mannerisms known and adapted by those of a particular culture (Greene, 1995).

Much of the literature has brought attention to the racial and gender biases in health and healthcare delivery. Evidence has revealed that while minorities may be responding to the advice of their informal and formal networks, some strides have been made by health education, public health promotion messages, and an increased awareness of the significance of accessing the health care system for preventive screenings and care Although some of the issues that years ago kept older women out of the health care system still exist, many older women are now being accepted into the system. However, the system may still treat them differently.

Thus, the continuing challenge is to ensure not just access, but also the availability of culturally competent, appropriate care. Formal helpers must routinely draw on localized knowledge to find meaning in illness or trouble and cannot ignore interpretations of misfortune,

however odd they may seem. They must gather information about how people solve problems within their own communities and what individuals would consider to be reasonable outcomes to those efforts (Greene, 1995). Developing a culturally competent and culturally confident practice requires helpers to understand clients' behaviors and needs, from the clients' perspective, in their own words, and through their own experience.

Like health professionals, social workers will be faced increasingly with the responsibility of serving, advocating for, and making policy decisions regarding the geriatric population, and more specifically for older women. Social workers must understand the nuances and cultural norms of these women, as with other populations they work with, and then work in partnership with them to integrate the recommended treatment plan within the context of their environments, life styles, values and belief systems. Doing this will empower both the consumer and the "helper/provider." Inclusion of these issues in social work education is very important, and will be central to the profession's carrying into the 21st century its historic commitment to advancing social and economic justice.

Building trust with and compassion for older women are critical factors and social work professionals must consider the roles of culture, the family, the social network, and the community in our interactions with clients. Women make up the majority of the aged population in our country and are at great risk of becoming isolated. Social workers must be strong advocates for practice and policy that is not only culturally appropriate but also age and gender specific.

While the women in this small sample all reported accessing the formal healthcare system, many African American elderly may not. Because they rely heavily on cultural tradition (and I believe, lay consultation), the formal healthcare system is not always a first choice for

many of them (Office of Women and Minority Health, 1996). According to the Office of Women and Minority Health (1996), outreach is the most important aspect of delivering appropriate and quality health care to older Black women.

Several findings from this study illustrate the importance of 'language' and 'labels' and how words, concepts, and even actions can mean different things to different people. For some of the women interviewed, the term 'advice' seemed to imply seeking assistance from someone having a higher level of knowledge or awareness; they perceived what they were doing as a simple form of exchange, which is common to the African American culture. Understanding the meaning of words, therefore, is critical because otherwise we risk planning interventions that are not appropriate or effective. It is also important for social workers to ask and be aware of the kinds of health information their clients are receiving from their peers (lay consultation), to understand the value of that exchange in their client's decision making process, and to provide education that ensures that information exchange is accurate.

Generally, many of the older Black women in this study demonstrated a strong faith in God, but also perceived the power of God working through their doctors to address their health needs. Social workers can effect change by assessing the total needs of the person, physically, mentally and spiritually and by better understanding patterns of social support and affiliation with both informal and formal networks. Through this more comprehensive assessment we can draw on the strengths of the person by asking what role religion plays in their health behavior or their help-seeking behavior, including how it influences access to formal care and relationships with and trust in physicians and other formal helpers. While we do not have to agree with clients' religious beliefs, showing respect for them is a powerful way to engage and support our

clients and can go a long way in building trust and credibility so that our clients will be comfortable in talking about their beliefs and perceptions.

These women are at risk for depression as a result of isolation and numerous losses, and they may believe they have to work through that depression themselves without the benefit of professional help. Some women in this study believed that depression is something other than a health problem and they felt responsible for creating their own sadness. Given the trust older adults may have in the doctors, this poses a great opportunity for primary care physicians to engage their patients about sadness, mood changes, and other symptoms that might reveal depression. Most likely, older adults will not bring up these issues themselves. Social workers will need to encourage doctors to engage in this dialog with the doctor when they perceive there might be a problem. Since social workers can also advocate for religious leaders to become better equipped to identify depression among their individual congregants and to make appropriate referrals.

Lastly, social workers must never underestimate the significance and power of language. Often we make assumptions about the meaning and value of words and experiences based on our own frame of reference. 'Advice seeking' implies that there is some level of knowledge differential; however, as social workers it is importance to for us to attempt to understand and base intervention on the behavior of our clients and not just the words used to describe it. Our interventions can also be better informed, perhaps, by our seeking to understand what our clients learn through lay consultation and how those beliefs shape their behavior and acceptance (or not) of our proposed interventions.

6.5 FUTURE RESEARCH

To inform social work interventions and practice, more qualitative research is needed on older Black women. I would especially like to conduct a qualitative analysis using the Chrisman (1977) concepts applied to a much larger sample of older Black women. Further research could examine beliefs they have about the formal care system itself; expanding not only on perceptions of care but on expectations they hold during the physician-patient encounter. Such studies also could assess how participation in social support networks influences the entire experience of prevention, illness, and health-seeking.

Further research should include an investigation of physician referral patterns, especially considering the under-representation of Black physicians (Institute of Medicine, 2003). Is there a preference among older patients? What is that preference based on? How might the lack of a preferred race or gender affect adherence? Additionally, future studies could investigate if trust issues for the older population generally are different from the findings of the present analysis of older adults in a particular geographical area.

Finally, several investigations have documented racial and gender bias in health care delivery (Schulman, 1999; IOM, 2003). The findings of these studies, as well as those of the recent State of Health and Aging report (Musa et al., 2003), suggest the existence not only of racial and gender biases but of age bias as well. Future research should focus on the intersection of these three forms of discrimination and their individual and joint contributions to health disparities and differential health care provision.

6.6 CONCLUSION

It has becomes increasingly clear that the historical and cultural contexts of preventing or responding to a health problem or issue are extremely significant in understanding contemporary patterns of health beliefs and practices, especially as they are translated into behavior. This means understanding the concept of culture and its relationship to beliefs and practices when providing care and services. Increased understanding may lead to better informed interventions at the individual, family, and the community level, integrating the natural helping resources of a community and culture and ensuring that whatever strategies and interventions are developed, are done so within the context – age, gender, culture, education and socio-economic status -- of the individuals being targeted. Experts in cross-cultural education have cautioned that the essence of cultural competence is not mastery of "facts" about different ethnic groups, but rather a patient-centered approach that incorporates fundamental skills and attitudes that can be applicable across ethnic boundaries (Tervalon, & Murray-Garcia, 1998; Carrillo, Green, & Betancourt, 1999).

While the struggles and hardships do not let up, it appears that many aging minority women are able to draw on strengths – psychological, social, and cultural – to perhaps ease the transition to old age. They have spent their lives as strategists, marshalling scarce resources with everyday demands, and these coping strategies 'pay off' later on in self-reliance (Padgett, 1989). The Chrisman concepts helped to bring 'life' to their voices.

When considering these concepts, the one that is most interesting to me is the lay consultation component, which I believe is a central theme influencing the other components (symptom definition, illness-shifts in role behavior, treatment actions and

adherence) and determining at what level an individual participates in the health-seeking process. According to Chrisman (1977), the lay referral concept was designed to indicate the relative likelihood that group members would consult a formal health professional for their health problems. However, it also serves to identify the interactive processes involved in health-seeking, whether or not a practitioner is consulted (Chrisman, 1977).

I think we often believe individuals seek consultation in response to a problem when in fact the consultation is on-going and often initiated or reinforced by those messages that occur within cultural communities. Individuals are consistently sharing and seeking information at a lay level, even before problems have been identified through symptoms or otherwise. I believe lay consultations are the basis for perceptions of care, preferences, practices, health beliefs, and self-care actions. Lay consultation also frames expectations about what should happen when we do seek formal care. The findings in this study suggest that respondents participate in lay consultation a good deal of the time yet not identifying it as such. Given the female bonds created through shared experiences, friendship, sisterhood, and 'singleness,' I think one respondent said it best when asked if she sought advice about her health problem:

> We always talk about our health. Sure. That's all we have much now to talk about. We don't have no boyfriends so we talk about our illnesses.

This statement represents the way in which I believe Black women – at all ages -- are in a constant state of lay consultation with each other; therefore, within this cultural context, they most likely would not consider this interaction advice seeking. Such ongoing and continual lay consultation illustrates the importance of language in the

context of the individual and affords an opportunity for continued learning and growing, given these women have accurate information to exchange. The challenge then becomes not only creating greater access to health resources but also creating: (a) opportunities for mutual learning between older Black women, public health social workers and health practitioners; and (b) health interventions and messages that are culturally tailored for Black women of all ages so they will become better armed for older age.

APPENDIX

HEALTH BEHAVIOR QUESTIONARE

IN-HOME INTERVIEW

SUPPLEMENTAL GRANT

GERIATRIC HEALTH CARE AND ASSESSMENT

A Controlled Randomized Prospective Study

Conducted By The University of Pittsburgh's

Graduate School of Public Health

And The Department of Medicine

Patient Name: (**Fn5**)_____(**Ln5**)_____Id: (**Pn**)

Patient Age: (**Age5**)

Unpaid Caregiver (If Any) Id Number: (**Cgpn5**)

Unpaid Caregiver Name: (**Cgfn5**)_____(**Cgln5**)

Unpaid Caregiver Relationship to Patient: (**Cgrel5**)

Has unpaid caregiver changed since last interview?

Yes__ No__ Not Applicable__ (**Cchange5**)_____

Paid Caregiver (If Any): (**Paidcg5**)

Yes __ No __ Type: (**Paidcgt5**)

Date of Interview: (**Indate5**)____/____/

Month Day Year

Interview Time: Begin Interview:_____ End Interview

Total Minutes: (**Alltime5**)_____ (**Intime5**)

Name Relationship

Persons participating in interview:

(anyone in addition to patient)

Additional person(s) present:

(Part5)____ (**Pres5**)

I. Health Status And Demographics

1a. Where were you born?

_____ _____
City (Or Town) **State (Or Country If Not Us)**

1b. Where did you mostly live while you were growing up? (if pt mentions more than one place, probe for place lived most between ages 6-16).

_____ _____
City (Or Town) **State (Or Country If Not Us)**

1c. Was that in a rural or country area, a small town, a small city, a suburb of a city, or in a large city?

___1 Rural or Country Area **(Born5)** _____
___2 Small Town
___3 Small City
___4 Suburb of a City
___5 Large City
___7 Other
Specify: _____

2. How would you rate your overall health at the present time--compared to other people your age--excellent, good, fair, or poor?

___ 1 Excellent **(Health5)**
___ 2 Good
___ 3 Fair
___ 4 Poor
___ 9 Not Answered

3. Is your health now better, about the same, or worse than it was the last time we interviewed you. That was in _____, about _____months (or years) ago. **(Month) (Year)**

___ 1 Better **(Hlthch5)**
___ 2 About the Same
___ 3 Worse
___ 9 Not Answered

4. How much do your health troubles stand in the way of your doing the things you want to do--not at all, a little (some) or a great deal?

___ 1 Not At All **(Hinway5)**
___ 2 A Little (Some)
___ 3 A Great Deal
___ 9 Not Answered

5. How much bodily pain have you generally had during the past 4 weeks? (on a range from "none" to "very severe")

___ 1 None **(Bpain5)**
___ 2 Very Mild
___ 3 Mild
___ 4 Moderate
___ 5 Severe
___ 6 Very Severe
___ 9 No Response

6. During the past 4 weeks, how much have you been bothered by emotional problems (such as feeling anxious, depressed, or irritable)? (on a range from "not at all" to "extremely")

___ 1 Not At All **(Emotion5)**
___ 2 Slightly
___ 3 Moderately
___ 4 Quite A Bit
___ 5 Extremely

7. During the past 4 weeks, how much difficulty did you have doing your daily chores, both inside and outside the house, because of your physical health or emotional problems?

___ 1 None At All **(Chores5)**
___ 2 A Little Bit
___ 3 Some
___ 4 Quite A Bit
___ 5 Could Not Do Daily Work

7a. If you had difficulty, what was the cause? Was it physical, emotional, or both?

___ 1 Mostly Or Entirely Physical **(Cause5)**
___ 2 Mostly Or Entirely Emotional
___ 3 Physical And Emotional About Equally
___ 4 Not Applicable

8. During the past 4 weeks, to what extent have your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups? (on a range from "not at all" to "extremely")

___ 1 Not At All **(Social5)**
___ 2 Slightly
___ 3 Moderately
___ 4 Quite A Bit
___ 5 Extremely

II. Health Care Practices

9. I'm going to read you a list of places where people go to get medical help. After I read each one, I'd like to know if you have gone to that place or person when you needed medical help.

A. Have you ever gone to a private doctor?

1yes_____ 2no_____ (**Godoc5**) _____

B. (Have you ever gone to) a public health clinic?

1yes_____ 2no_____ **(Gophc5)** _____

C. A Social Worker?

1yes_____ 2no____ **(Gosowo5)** ____

D. Have you ever had contact with a visiting nurse?

1yes_____ 2no_____ **(Govn5)** _____

E. A hospital emergency room?

1yes_____ 2no_____ **(Goer5)** _____

F. A hospital outpatient clinic?

1yes_____ 2no_____ **(Goclin5)** _____

10. Here is a list of other people one might go to for help. Please tell me if you have gone to any of these people. **(check all that pt mentions).**

A. Faith Healer

1yes_____ 2no_____ **(Faith5) _____**

B. A Person Who Does Acupuncture

1yes_____ 2no_____ **(Acup5) _____**

C. A Person Who Heals With Roots Or Herbs

1yes_____ 2no_____ **(Herb5) _____**

D. A Person Who Practices Astrology Or Reads Zodiac Signs

1yes_____ 2no_____ **(Astrol5) _____**

E. A Person Who Reads Tea Leaves, Roots Or Palms

1yes_____ 2no_____ **(Leaves5) _____**

11. I'm going to read you a list of common health problems. After I read each one, please tell me whether that problem would cause you to seek help?

A. A Persistent Stomach Problem

1yes___ 2no___ 3dos*___ **(Stom5) _____**

B. Persistent Headaches

1yes___ 2no___ 3dos_____ **(Head5) _____**

C. Persistent Pain

1yes_____ 2no_____ 3dos_____ **(Perpain5) _____**

D. Not being able to get around as much as you used to

1yes_____ 2no_____ 3dos_____ **(Move5) _____**

E. Forgetting more often than you used to

1yes_____ 2no_____ 3dos_____ **(Forgets5) _____**

F. Feeling sad a lot of the time

1yes_____ 2no_____ 3dos_____ **(Sad5) _____**

G. Just not feeling good all over

1yes_____ 2no_____ 3dos_____ **(Bad5) _____**

H. A Fever

1yes_____ 2no_____ 3dos_____ **(Fever5) _____**

(*Dos = Depends On Situation)

12. In the past 6 months to a year, have you had any health problems that you sought help for? (that you went to a doctor, nurse, chiropractor, healer, dentist, specialist, etc., for.)

1yes___ 2no___ **(Help5) _____**

If No, Ask: have there been any health problems over the past few years that you have sought help for?

If No, Ask: is there any health problem that you are under treatment for now?

If No To All Above, Go To Question 13, Page 10

If Yes To Any Of The Above:

List The Problems:

_____
_____
_____

12a. Which one of those problems that you've told me about (listed) do you think was the most serious?

_____
_____

(For The Following Questions [Q12b Through q12f] Use The Most Serious Problem Prompts [Prompts A - Page 7] Unless The Problem Was A Medical Emergency, E.G., Stroke, Heart Attack, Fall, Etc., In Which Case Use The Medical Emergency Prompts [Prompts B - Page 8], And Focus More On The Recovery And Rehabilitation Process.)

12b. What did you do about _____? **(Tell me about the most serious problem.)**

Encourage pt to describe the experience. Cover, at minimum, the probes listed in prompts a or b but not necessarily in the order listed.)

Prompts A: Serious Problem

(1) How did you first decide that you had a problem?

(2) What do you think caused the problem?

(3) What made you decide that you needed help?

(4) Did you ask anyone's advice about what to do or where to go, such as a family member, friend, neighbor, minister? Who did you ask first? **(Try to get pt to list the people in the order in which she/he asked their advice.)**

Is that (are they) who you usually ask? Why?

(5) Who or where did you go to get help first?

(6) How did you decide to go there?

(7) How did you get to (the provider)? **[What was the means of transportation?]**

(8) What did (provider) tell you to do?

Did you follow his/her advice? If not, why not?

(9) Did you feel that (provider) was concerned & willing to listen to you?

(10) Did you have confidence in (provider) (did you think (provider) was a good (doctor, chiropractor, etc.)

(11) Did (provider) or staff (if applicable) make you feel uncomfortable in seeking help? If so, in what way?

(12) Was (provider) able to help you? Why or why not?

If the provider:

Was able to help, ask: Did you go to anyone else for help? **(Probe for type of help/provider.)**

Was not able to help, ask: Did you go to anyone else for help?
(Then, if pt went elsewhere cover prompts #6 through 12 again)

(If the second provider wasn't able to help either, ask again if anyone helped and cover prompts #6 through 12 again. Repeat again if necessary.)

Prompts B: Medical Emergency

(1) Did you know that you had a problem before?

(2) Did you seek help for this problem before the emergency?

If not, why not?

(3) Did you ask anyone's advice about what to do or where to go, such as a family member, friend, neighbor, minister?

Who did you ask first? **(Try to get pt to list the people in the order in which she/he asked their advice)**

Is that (are they) who you usually ask?

Why?

(4) What happened after you received emergency care?

Who helped you with the problem afterward?

(5) How did you decide to use (that provider)?

(If answer is "my doctor," or other provider that pt typically uses, ask): How did you first decide to go to him/her?

(6) What did (provider) tell you to do?

Did you follow his/her advice?

If not, why not?

(7) Did you feel that (provider) was concerned & willing to listen to you?

(8) Did you have confidence in (provider)? (Did you think (provider) was a good (doctor, chiropractor, etc.)?

(9) Did (provider) or staff (if applicable) make you feel uncomfortable in seeking help?

If so, in what way?

(10) Was (provider) able to help you?

Why or why not?

If the provider:

Was able to help, ask: did you go to anyone else for help? **(Probe for type of help/provider.)**

Was not able to help, ask: did you go to anyone else for help? **(Then, if pt went elsewhere cover prompts #5 through 10 again)**

(If the second provider wasn't able to help either, ask again if anyone helped and cover prompts #5 through 10 again. Repeat again if necessary.)

12c. In addition to these things we've talked about, did you do anything on your own to make you feel better? (Either before, during, or after seeking help.)

1 yes ___ 2 no **Ownhelp5)**

Prompts:

(1) take medication used before?
(2) take someone else's medication?
(3) take over-the-counter medication?
(4) use heating pad?
(5) use home remedies?
(6) other?

12d. When you were having this problem, did you get any support or services from family, friends, church, neighbors, or others?

1 yes ___ **(continue)** 2 no ___ **(go to 12f)** **(support5)**_____

If **yes**, what kind of support did you get?

Prompts:
(1) transportation
(2) help with housework, shopping, etc.
(3) emotional support
(4) talking things over
(5) just advice
(6) food brought in
(7) other

12e. Was this enough help? **(Would you have liked to have more help?)**

1 yes ___ **(Go to question 13, page 10)**
2 no __
3 DK ___

12f. Did you want help?
1 yes __
2 no __

13. What kinds of problems would you go to the hospital emergency room for?

14. Do you know anyone who has the problem of memory loss, or sometimes becoming forgetful or confused?

1 yes ___
2 no ___ **(Go To Question 15a, Page 11)** (**Memlos5**)

(If yes, ask pt to describe the person and his/her problem. Cover prompts listed below.)

(1) How serious is it?
(2) What do you think caused it?
(3) What can be done about it? **(can it be treated?)**
(4) What can happen to a person who has it?
(5) Where should a person go to get help with it?

(Ask the following question [15] only if you do not already know who the respondent's regular health provider is. If you know who the regular provider is, record the information, and ask questions 15a through 15g.)

15. Are any of the sources of help for health problems that you mentioned earlier your regular source of health care? **(By that I mean for your regular check-ups or the health problems you have from time to time?)**

1 yes ___ **(Continue)**
2 no ___ **(Go To Question 16a, Page 12)**

(If Yes)

15a. How did you first decide to go to your (regular provider)?

15b. How do you usually get to (the regular doctor)? **[What is the means of transportation]**

15c. How often do you go to (regular provider)?

15d. When was the last time you went?

15e. Do you feel that (regular doctor) is concerned & willing to listen to you?

15f. Do you have confidence in (regular doctor) (Do you think (regular doctor) was a good (doctor, chiropractor, etc.)

15g. Does (regular doctor) or staff (if applicable) make you feel uncomfortable in seeking help?

If so, in what way?

(Go to question 17, page 13)

16a. Do you have a person or place that you go to for your regular care? **(by that I mean for your regular check-ups or health problems you have from time to time?)**

1 yes ___ **(Continue)**
2 no ___ **(go to question 17, page 13)** (**regdoc5**)

(If yes:)

16b. Who is your regular source of health care? **(Who do you usually go to for health care?)**

a. How did you first decide to go to (regular provider)?

b. How do you usually get to (the regular doctor)?

[What is the means of transportation]

c. How often do you go to (regular provider)?

d. When was the last time you went?

e. Do you feel that (regular doctor) is concerned & willing to listen to you?

f. Do you have confidence in (regular doctor) (do you think (regular doctor) was a good (doctor, chiropractor, etc.)

g. Does (regular doctor) or staff (if applicable) make you feel uncomfortable in seeking help? _____

If so, in what way?

17. In general, have you been satisfied with your regular source of health care?

1yes ___2no ___ **(Satis5)**

Why or why not?

18. Have any of your (providers) been black? **(Blackmd5)**

1yes ___ 2no ___

19. Would you rather go to someone who is black? **(Likeb5)**

1yes_____ 2no_____ 3don't care_____

20. Have any of your (regular doctors) been women? **(Femmd5)**

1yes_____ 2no_____ 3don't care_____

21. Would you rather go to someone who is a woman? **(Likefem5)**

1yes_____ 2no_____ 3don't care_____

22a. Overall, how hard has it been for you to get medical treatment or health services that you needed?

___ 1 very hard **(continue on** **(Treat5)**
___ 2 fairly hard **next page, q22b)**
___ 3 not too hard **(go to question 23,**
___ 4 not hard at all **on next page)**

(if very hard or fairly hard on q22a:)

22b. Why was it hard for you to get this help? **(Whyhard5)**

(Encourage pt to discuss the situation. Consider following reasons as possible prompts.)

(1) access--it was a long way away (lived in rural or remote area); it was difficult to get transportation.

(2) didn't have money or insurance to pay for it

(3) couldn't get an appointment--because of being black; because the facility was overloaded; etc.

(4) had family responsibilities that kept me from going

(5) didn't know where to go for help

(6) other_____

23. Are there some health problems that you treat yourself (e.g. colds, allergies, back pain, etc.)?

1yes___ 2no___ **(Treatsl5)**

24a. In the past 6 months to a year, have you had any health problems that you felt you could take care of yourself.

1 yes___ **(continue)**

2 no ___ **(go to question 25a, next page)** **(Slfcar5)**

if yes, list:

(Interviewer choose one problem, ask q24b on next page)
(For one problem from q24a:)

24b. What did you do about this problem?

(Encourage pt to describe the experience. Cover, at minimum, the prompts listed below, but not necessarily in that order)

Prompts

(1) How did you first decide that you had a problem?

(2) What do you think caused the problem?

(3) Did you ask anyone's advice about what to do or where to go, such as a family member, friend, neighbor, minister? Who did you ask first?

(Try to get pt to list in order the people she/he asked advice of)

Is that (are they) who you usually ask? Why?

25a. Did your family ever use any home remedies to cure illnesses while you were growing up?

1yes ____2no ____**(homrem5)**

(Ask for some examples of home remedies used--an exhaustive list is not necessary.)

25b. Do you still use home remedies all of the time, sometimes, or never use them now? **(usehr5)**

___ 1 all of the time
___ 2 sometimes
___ 3 never use them now
___ 9 no response

iii. Health Knowledge/Beliefs

We have talked about some of your specific problems, now I'd like to ask you some questions about health in general.

26. How much do you agree with the following statements? **(hand card):**

Don't agree agree agree not at all a little agree very much

Response:

A. Many health problems that older people have are caused by old age and can't be helped. **(Ft5)**_____

1 2 3 4 9

B. People who take care of themselves stay healthy. **(pr5)_____**

1 2 3 4 9

C. I don't believe doctors can do everything they say they can do. **(Sk5)_____**

1 2 3 4 9

D. A person understands his/her own health better than most doctors. **(Sk5)_____**

1 2 3 4 9

E. Some home remedies are still better than the medicines the doctor gives you for curing sickness. **(Al5)_____**

1 2 3 4 9

F. I have no reason to worry about diseases because I can always go to my doctor and get cured. **(Po5)_____**

1 2 3 4 9

G. Sometimes when you're sick, someone you know can help you get well better than a doctor can. **(Al5)_____**

1 2 3 4 9

don't agree at all	**agree a little**	**agree**	**agree very much**	**no response**

H. God will take care of me so I don't worry too much about my health.

1 2 3 4 5

I. Sooner or later, medicine is going to solve everybody's health problems. **(Po5)_____**

1 2 3 4 9

J. There are a lot of things you can do to stay healthy and avoid illness. **(Pr5)_____**

1 2 3 4 9

27. Next I'm going to read you a list of sources from which people often get information about health. After I read each one, please tell me if you get health information from that source.

a. Radio (specify source if one program)

1yes_____ 2no_____**(radio5)_____**

b. Television (specify source if one program)

1yes_____ 2no_____**(tv5)_____**

c. Reading (specify source)

1yes_____ 2no_____**(read5)_____**

d. Friends

1yes_____ 2no_____ **(frnd5)_____**

e. Relatives

1yes_____ 2no_____**(rel5)_____**

f. Church

1yes_____ 2no_____**(church5)_____**

g. Senior center presentations

1yes_____2no_____**(sc5)_____**

h. Mail **(information that comes in the mail)**

1yes_____2no_____ **(mail5)_____**

i. Health care personnel **(physician/nurse/pharmacist, etc.)**

1yes____ 2no_____**(hcp5)_____**

j. Other

1yes ___ 2no___**(oth5)_____**

27a. Which one of these sources do you get most of your information from?

(source5)_____

IV. Social support

Now I'd like to ask you a little bit about your family and your friends.

28. In the past year how often have people in your family --including children, brothers, sisters, nieces, nephews, in-laws and so on -- helped you out? Would you say very often, fairly often, not too often, or never? **(famhlp5)**

__ 1 very often
__ 2 fairly often
__ 3 not too often
__ 4 never
__ 5 never needed help
__ 9 no response

28a. **If pt answers "never" or "never needed help," ask:** Would they help you if you needed help?

1 yes ____ 2 no ____ **(fwhlp5)**

29. In the past year, how often have people in your church or place of worship helped you out. Would you say very often, fairly often, not too often, or never?

__ 1 very often **(chlp5)_____**
__ 2 fairly often
__ 3 not too often
__ 4 never
__ 5 never needed help
__ 7 not applicable (doesn't go to church)
__ 9 no response

30. In the past year, how often have other people (people not in your family or church) helped you out? Would you say very often, fairly often, not too often, or never? **(othhlp5)**

__ 1 very often
__ 2 fairly often
__ 3 not too often
__ 4 never
__ 5 never needed help
__ 9 no response

30a. **If pt answers "never" or "never needed help," ask:** Would they help you if you needed help?

1 yes ___2 no ____ **(owhlp5)**

31. When we last talked to you, you said your income was in the range from _____ to ____.

Has there been any change in your income since then?

1 yes ___ 2 no ___**(ichange5)**

If income has not changed, conclude interview by thanking participant.

If income has changed, say:

31b. Please look at this card. **[hand card]** Which of these income groups represents your (and your husband's/wife's) personal income for the past year? Include income from all sources such as wages, salaries, social security or retirement benefits, help from relatives, rent from property, and so forth **(Income5)**

___ 1 under $5,000
___ 2 $5,000 to 10,000
___ 3 $10,000 to $20,000
___ 4 $20,000 to $30,000
___ 5 $30,000 to $40,000
___ 6 $40,000 - and over
___ 7 n/a (no change)
___ 9 not answered

Conclude interview by thanking participant.

Brief comments on interview:

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